Nos. 79-4, 79-5 and 79-491

In The

Supreme Court of the United States

October Term, 1979

No. 79-4

JASPER F. WILLIAMS, M.D., and EUGENE F. DIAMOND, M.D.,

Appellants,

v.

DAVID ZBARAZ, M.D., MARTIN MOTEW, M.D., individually and on behalf of all others similarly situated; CHICAGO WELFARE RIGHTS ORGANIZATION, an Illinois not-for-profit corporation; and JANE DOE, individually and on behalf of all others similarly situated,

Appellees.

No. 79-5

JEFFREY MILLER, Acting Director, Illinois Department of Public Aid,

Appellant,

v.

DAVID ZBARAZ, M.D., MARTIN MOTEW, M.D., individually and on behalf of all others similarly situated; CHICAGO WELFARE RIGHTS ORGANIZATION, an Illinois not-for-profit corporation; and JANE DOE, individually and on behalf of all others similarly situated,

Appellees.

No. 79-491

UNITED STATES OF AMERICA,

Appellant,

v.

DAVID ZBARAZ, M.D., MARTIN MOTEW, M.D., individually and on behalf of all others similarly situated; CHICAGO WELFARE RIGHTS ORGANIZATION, an Illinois not-for-profit corporation; and JANE DOE, individually and on behalf of all others similarly situated,

Appellees.

On Appeals from the United States District Court for the Northern District of Illinois

BRIEF OF APPELLEES

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BRIEF OF APPELLEES

OPINIONS BELOW

The Brief for the United States (at 2) adequately sets forth the opinions below.

JURISDICTION

The Brief for the United States (at 2) adequately sets forth the grounds on which the jurisdiction of this Court is invoked. Further discussion of the Court's jurisdiction appears at pp. 28-37 *infra*.

QUESTIONS PRESENTED

1. Does the fourteenth amendment permit Illinois to deny medically necessary abortion services to indigent pregnant women, while providing all other medically necessary services under its medical assistance programs for the poor?

2. A. Does Title XIX of the Social Security Act allow Illinois to provide medically necessary care generally to all recipients for all conditions, except services for pregnant women suffering from conditions making an abortion medically necessary?

B. Do successive riders to annual HEW appropriations laws, providing that no federally appropriated funds shall be used to perform abortions except in narrow circumstances, impliedly repeal all the requirements imposed by Title XIX on the states with regard to medically necessary abortion services?

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

1. The Fourteenth Amendment to the Constitution of the United States:

> No state shall . . . deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

2. The Social Security Act, 42 U.S.C. §§ 1320c(1) (1976); 1320c-1(a), (b)(1), (e) (1976), *as amended by* Pub. L. No. 95-142, § 5(a), (o)(1), 91 Stat. 1175 (1977); 1320c-4(a)(1)(A), (B), (2) (1976), *as amended by* Pub. L. No. 95-142, § 5(d)(3)(B)(i), (o)(2), 91 Stat. 1175 (1977); 1320c-5(a), (b) (1976); 1320c-7(a) (1976), *as amended by* Pub. L. No. 95-142, § 22(a)(1), 91 Stat. 1175 (1977); 1320c-8 (1976); 1320c-9 (1976), *as amended by* Pub. L. No. 95-142, § 5(e), (o)(3), 91 Stat. 1175 (1977); 1320c-13 (1976); 1320c-20(d)(1), (3)(A) (1976), *as amended by* Pub. L. No. 95-142, § 5(d)(2)(D), 91 Stat. 1175 (1977); 1396 (1976); 1396a(a)(10), (13)(A)-(C), (17), (19), (22), (30) (1976); 1396b(a)(1)-(6) (1976), *as amended by* Pub. L. No. 95-142, §§ 10(a), 17(a), 91 Stat. 1175 (1977); 1396b(p) (1976), *as amended by* Pub. L. No. 95-142, § 11(a), 91 Stat. 1175 (1977); 1396d(a) (1976), *as amended by* Pub. L. No. 95-210, § 2(a), 91 Stat. 1485 (1977). These statutes are reprinted at Appendix B hereto, pp. 4a-23a *infra*.

3. Joint Resolution (H. J. Res. 440) making further continuing appropriations for the fiscal year 1980, Pub. L. No. 96-123, § 109, 93 Stat. 923 (1979), reprinted in the Appendix to the Brief for the United States at 1a.

4. Regulations of the United States Department of Health, Education and Welfare, 42 C.F.R. §§ 435.903,

440.210-.230, .260 (1979), reprinted at Appendix C hereto, pp. 24a-25a *infra*.

5. ILL. REV. STAT. ch.23, §§ 5-5, 6-1, 7-1 (Supp. 1977), reprinted in the Appendix to the Brief for the United States at 2a-4a.

6. Medical Assistance Program Rules of the Illinois Department of Public Aid (as contained in the Handbooks for Physicians and for Hospitals), reprinted in the Appendix to Appellant Miller's Brief at 7a-67a, and at Appendix A hereto, pp. 1a-3a *infra*.

STATEMENT*

A. The Illinois Medical Assistance Programs.

About one million indigent persons in Illinois participate in the state's medical assistance programs: the Medicaid and the state-funded General Assistance ("GA") and Aid to the Medically Indigent ("AMI") programs (IDPA, ANNUAL REPORT 1978, at 19, 28). With the single exception of abortion services (P.A. 80-1091, ILL. REV. STAT. ch.23, §§ 5-5, 6-1, 7-1 (Supp. 1977) at U.S. App. 3a-4a**), the Illinois legislature has mandated

* The prior proceedings in this case are adequately set forth in the Brief of the United States at pp. 6-15.

** The following designations are used to refer to the documents filed with this Court in this litigation:

"U.S. Br." or "U.S. App."—Brief or Appendix to the Brief of the United States (No. 79-491);

"St. Br." or "St. App."—Brief or Appendix to the Brief of Appellant Miller (No. 79-5);

"Int. Br."—Brief of Intervenors (No. 79-4);

"U.S.J.S. App."—Appendix to the Jurisdictional Statement of the United States;

"A."—Appendix; "R"—Record item (numbered according to the list of items transmitted to this Court by the district court on June 20, 1979).

that these programs cover necessary medical care.* Payments for services are made to the medical providers, not to recipients. Every recipient receives a medical eligibility card which, when presented to a participating provider, entitles the recipient to services (St. App. 8a: § 110).

Except with regard to abortion services, the legislature has delegated to the Illinois Department of Public Aid ("IDPA") the task of promulgating rules for provision of services under the medical assistance programs. ILL. REV. STAT. ch.23, §§ 5-5, 6-1.3, 7-2. These rules (portions of which are reprinted at St. App. 7a-67a), declare as their objective the provision of "essential medical care . . . necessary to preserve health [and] alleviate sickness" (St. App. 7a: § 102) and define covered services generally as "reasonably necessary medical and remedial services . . . recognized as standard medical care required because of illness, disability, infirmity, or impairment, and which are necessary for immediate health and well-being" (*id.* at 13a: § A-203; *see id.* at 7a: § 102).

This general standard is reiterated in the context of particular services. For example, "[c]overed surgical procedures which are medically necessary are allowable" (St. App. 43a: § A-242.2; *see id.* at 14a: § A-204.s, 17a: § A-205.2). Office visits to a physician in connection with a particular medical problem are covered (*id.* at 24a: § A-220), as are "essential inpatient, outpatient and clinic diagnostic and treatment services"

* "Essential medical care," ILL. REV. STAT. ch.23, § 5-1 (Medicaid); "any necessary treatment . . . required because of illness or disability," ILL. REV. STAT. ch.23, § 6-1 (U.S. App. 4a) (GA); and "necessary medical . . . care," ILL. REV. STAT. ch.23, § 7-1 (U.S. App. 4a) (AMI).

(*id.* at 51a: § H-203). The "medical necessity" of inpatient hospital admission and the "medical necessity" of the length of stay are the standards for approving coverage of inpatient hospital services (*id.* at 59a: § H-213). None of the services, except abortion, is subject to the condition that it be necessary to preserve the recipient's life.*

The Illinois medical assistance programs cover some services which are not "medically necessary" (*see, e.g.*, St. App. 17a: § A-205.2, 40a: § A-226). But in general the programs exclude coverage of non-medically necessary services (*id.* at 14a: § A-204, 53a: § H-204.17).**

B. Medical Assistance Program Abortion Services In Illinois.

Prior to the legalization of abortion in Illinois in 1973, thousands of indigent Illinois women required hospitalization for the effects of illegal or self-induced abortions (R.22: ¶5; R.17: Exh.H). Many of these women suffered serious medical complications (R.22: ¶7; R.17: Exh.H). A large number had to undergo surgery, including, in a number of cases, removal of the uterus (R.22: ¶7). The legalization of abortion contributed to a dramatic reduction in illegal and self-induced abortions, in the abortion mortality rate, and in the number of medical complications arising from abortions (R.22: ¶s11-14; R.17: Exhs.F-6, -8, H-2).

* Because of the injunction in this case, the current rules allow reimbursement for medically necessary abortions (St. App. 15a: § A-205.1).

** For the non-medical necessity of some of the treatments limited or excluded by the Illinois program, *see* R.100: p.6-7n.

From the time of the legalization of abortion until the passage of P.A. 80-1091, the statute at issue in this case, the Illinois medical assistance programs covered all abortion services—both medically necessary and elective—for indigent pregnant women. During 1977, the last year of such coverage, IDPA paid for 25,104 abortions (R.20: Exh.C); of those abortions, 1,330 were performed for teen-agers 15 years old and younger (*id.*).

P.A. 80-1091 went into effect on December 15, 1977, but because of various injunctions in this case, Illinois has been required to cover all medically necessary abortions almost continuously since January 11, 1978.* During 1978, the Illinois medical assistance programs covered 10,666 medically necessary abortions billed by physicians (R.101: Exh.F). This compares with 21,663 abortions billed by physicians during 1977 when the medical assistance programs covered both elective and medically necessary abortions (R.101: Exh.F-3).**

The costs of prenatal care, childbirth and post-partum care are over seven times the cost to the state of abortion (R.111: Exh.A; R.101: Exh.F). If the newborn child receives public aid, the cost differential is even greater

* The initial injunction was issued by the Seventh Circuit, pending appeal, on January 11, 1978. Subsequent injunctions were issued by the District Court on May 15, 1978 (R.64), and April 30, 1979 (R.122). The only time during this period that P.A. 80-1091 was in effect was from May 1 to May 14, 1978 (R.48: Exh.C-3).

** The difference in numbers of abortions covered for 1977 reported in the previous paragraph is because the larger number includes approximately 3,500 abortions billed by hospitals, in addition to the 21,663 abortions billed by individual physicians. At the time of Judge Grady's April 30, 1979, ruling, at which point the record closed, IDPA had not compiled figures for total abortions reimbursed (including those billed by hospitals) for 1978.

(R.17: p. 23n., Exh.E). Even when the state bears 100% of abortion costs and only 50% of childbirth costs (because federal matching payments are available for the latter), the average cost to the state of childbirth and support payments for the first year of the child's life is over nine times the average cost to the state of an abortion (R.111: p. 8n.2, Exh.A; R.101: Exh.F). The costs to the state of caring for women suffering complications from illegal or self-induced abortions (R.17: Exhs.E, H-2, -3; R.22: ¶s 5-10) and treating complications associated with pregnancy (R.111: p. 8n.2, Exh.B) make the cost differential even more dramatic (R.111: p.8).

C. Number Of Abortions Performed Under A Restrictive Standard Excluding Most Medically Necessary Abortions.*

To enable the state to receive federal reimbursement, medical assistance program providers have had to report the number of abortions performed which would meet the various funding standards in the appropriations acts popularly known as the annual Hyde Amendment. Reports on federal reimbursement to Illinois for such abortions provide a rough measure of the number of abortions that would have been covered under P.A. 80-1091.** During 1978, physicians certified to

* Appellees' challenge is to the restrictive standard of the Illinois legislation, P.A. 80-1091 (*see* p. 4 *supra*), and reference herein to the "Illinois standard" or the like is to that restrictive standard. Both factual and legal discussions, however, will necessarily draw on material addressed to the somewhat different and varying restrictive standards of the annual Hyde Amendments from 1978 to 1980.

** At the time these federal funding figures were reported, the Hyde Amendment funded abortions required because of "severe and longlasting physical health damage" in addition to those necessitated because the woman's life would be en-

(Footnote continued on following page)

IDPA approximately twenty-seven abortions a month as meeting Hyde Amendment standards (R.101: Exh.H). This total is less than 3% of medically necessary abortions Illinois physicians billed to IDPA in 1978 (R.101: Exh.F; R.100: p.9), and is only 1.3% of all abortions (both medically necessary and elective) performed in 1977 (R.20: Exh.C).* Physicians certified only 1.9% of all medically necessary abortions they billed to IDPA in 1978 as ones necessary to preserve the pregnant woman's life (R.101: Exh.F).

D. The Relationship Of Illinois' Abortion Funding Standards To Medical Practice.

The standards of P.A. 80-1091 and successive Hyde Amendments are alien to accepted standards of medical practice in several ways (*see* A.103: ¶4; A.119: ¶13; A.124: ¶5). First, the language of the restrictive standards calls for physicians to make, with respect to individual women patients, predictions that mortal injury

Footnote continued

dangered (U.S. App. 2a). Data from other states suggest that the different restrictive standards do not lead to substantially different numbers of certified abortions (R.101: Exh.G-8 to -12). In any case, the current Hyde Amendment is virtually identical to P.A. 80-1091 (U.S. Br. 9-10). Even the very small number of abortions reported in the text is thus likely to be somewhat larger than the number under either the current Hyde Amendment standard or that of P.A. 80-1091.

* HEW figures for the period from October 1, 1978, through June 30, 1979, show an even smaller number of federally reimbursed abortions certified in Illinois, averaging approximately thirteen abortions per month. DHEW, HEALTH CARE FINANCING ADMINISTRATION, OFFICE OF RESEARCH, DEMONSTRATIONS AND STATISTICS, QUARTERLY REPORT: MEDICAID FINANCED ABORTIONS UNDER P.L. 95-205 (August 11, 1979), at Attachment B; *see also McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 at 9977-78 (slip op. at 58-59) (E.D.N.Y. Jan. 15, 1980).

will certainly or very likely occur. The version of the Hyde Amendment in effect at the time of the district court decision required a physician to determine that the life of the pregnant woman "would be endangered,"* or that "severe and long-lasting physical health damage would result" without an abortion. P.A. 80-1091 requires a physician to determine that an abortion is "necessary for the preservation" of the pregnant woman's life. With rare exceptions, the current state of medical knowledge does not enable a physician to determine with reasonable certainty that a medical condition or illness will give rise to death (A.31: ¶7; A.103-04: ¶5; A.125-28: ¶6; A.114: ¶4, A.119-21: ¶s14,15).

Second, a physician ordinarily cannot predict, even with a lesser degree of certainty, either the severity or duration of health damage, or that pregnancy will result in death, or in shortening of life, or in some less severe damage (A.31: ¶7; A.33-34: ¶13; A.104: ¶6; A.125-28: ¶9). For example, a woman suffering from malnutrition or essential hypertension is at high risk of some adverse consequences as a result of pregnancy (A.34: ¶13). But whether either of these conditions in a particular woman is likely to result in preeclampsia (a condition characterized by significant elevation of blood pressure, significant protein loss in the urine, and edema, which in turn accelerate the likelihood of vascular disease, stroke, organ damage, and diabetes, A.32-33: ¶11), and whether the preeclampsia, if it arises, will cause a particular severe and long-lasting physical health problem, or a shortening of life, or

* These words "require a finding that an event *would occur* if the fetus were carried to term." HEW Comments on final regulations on federal funding under the Hyde Amendment, 43 Fed. Reg. 31876 (July 21, 1978) (emphasis in original).

death, is impossible for a physician to predict accurately (A.33-34: ¶s12, 13; A.104: ¶6; A.125: ¶6(a)).

Third, many conditions can be identified as posing a serious threat to life only late in pregnancy, when the time for safe abortion has passed (A.105: ¶8; A.121: ¶16). While a medically necessary abortion ordinarily can be performed safely early in the pregnancy, especially in the first trimester, the medical risks from abortion itself increase linearly thereafter (A.30: ¶5; A.105-06: ¶s8, 9; R.101: Exh.G-7). A woman with a preexisting uterine fibroid tumor, for example, is seriously threatened with complications (hemorrhage, spontaneous abortion, complications in labor) if the tumor grows (A.125-26: ¶6(b)). But the tumor often does not exhibit signs of growth until the second trimester of pregnancy, and a physician under the restrictive standards will thus be precluded from certifying a patient during the time that an abortion can be performed safely (A.126: ¶6(b)).* Even those conditions which have been identified as leading causes of maternal death in Illinois (*e.g.*, toxemia and hemorrhage) may not be diagnosed as life-threatening, rather than merely health-threatening, until mid- or late pregnancy (R.101: Exh.I-2; A.105: ¶8).

Fourth, physicians do not ordinarily make medical evaluations in terms of "life" risks. The standard thus

* A similar example emerges from the situation of plaintiff Jane Doe. Thus, Dr. Zbaraz could not—even during the second trimester of pregnancy—have certified Jane Doe under the Illinois or Hyde Amendment standards, even though her condition—severe varicose veins, previously surgically treated, and a history of thrombophlebitis—can, in some cases, result in death or severe and long-lasting physical health damage. Signs of such permanent consequences which would have permitted even an uncertain prediction might not have arisen in her case until comparatively late in pregnancy. (A.127: ¶6(d).)

has no meaning to them (A.104: ¶7; A.119: ¶s13, 14). Even if a physician could predict with reasonable certainty that pregnancy and childbirth would shorten a woman's life by several years, it is unclear whether this prospect would meet the standard (A.104-05: ¶7; *see* A.119-20: ¶14). The medical assistance program rules contain no other similar standards (St. App. 7a-67a). When IDPA has sent out notices and Physicians' Handbook revisions informing providers of its intent to implement either P.A. 80-1091 or the Hyde Amendment standards, it has repeated the language of the law without clarification or explication (R.17: Exh.B; R.101: Exh.A-2 to -4; R.114: Exh.F). The same is true of the Department of Health, Education and Welfare ("HEW") regulations (43 Fed. Reg. 31868-79 (July 21, 1978), 44 Fed. Reg. 61597-98 (Oct. 26, 1979)). The record offers no indication that a life-preservation standard could be clarified or explained in a manner physicians could apply.

Finally, physicians believe that the new abortion funding standards have been established with an intent to prevent abortions and, therefore, are reluctant to certify any patients under these standards (A.109: ¶15; A.120: ¶14).

Insofar as these factors require physicians to wait before certifying even a small number of abortions as meeting the standard, the effect is to restrict abortions to those performed after the 28th week of pregnancy. This would increase the risks of morbidity and mortality to indigent women (A.112; *see McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 at 9988-90, 10,005-06 (slip op. at 92-101, 157-58) (E.D. N.Y. Jan. 15, 1980)).

E. Application Of A Standard Of Medical Necessity To Provision Of Abortion Services.

"Medical necessity" is the standard by which physicians evaluate the need for medical intervention (A.106-07: ¶11; A.116: ¶6; A.129: ¶7). It is the standard, abortion excepted, for coverage of services under Illinois' medical assistance programs (*see* pp. 5-6 *supra*) and under federal law (*see* pp. 81-88 *infra*).

As applied to pregnancy and abortion, the standard of medical necessity enables a physician to determine, during early stages of pregnancy, that an individual pregnant patient with a particular health profile runs a higher than normal risk of adverse consequences to her health if her pregnancy is carried to term (A.106: ¶11). A physician's evaluation of what constitutes an excessive risk depends on a comparison with the risk to the population of healthy pregnant women (*id.*). Where a patient's condition presents an abnormal risk to her health, and she has a firm wish to terminate her pregnancy, an abortion is medically necessary (A.107: ¶11; A.128: ¶6(d); A.129: ¶7; *see McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 at 9990 (slip op. at 101) (E.D. N.Y. Jan. 15, 1980)).

The incidence of such abnormal risks varies with the characteristics of the patient population a physician sees and the medical judgment of individual physicians (A.107: ¶11). Within these parameters, it is estimated that between 20% and 50% of abortions that physicians perform are medically necessary (*id.*; *see* A.116: ¶7; A.38: ¶6; R.38: Exhs.A-3, C-2, D-5).

Numerous abortions which physicians deem to be medically necessary do not meet the Illinois standard (A.32-37: ¶s12-17; A.110-11: ¶17; A.114-15: ¶s4-5; A.125-28: ¶6; A.129: ¶8). Pregnant women suffering from es-

sential hypertension face a significant risk of developing convulsive seizures, hemorrhage, and aspiration pneumonia (A.110: ¶17). Pregnant women with sickle cell anemia risk kidney malfunction, hemorrhage, and sickle cell crisis which can result in death (*id.*; A.128: ¶6(e)). Malnutrition creates a much higher than normal risk of health injury: toxemia, infection, premature labor, anemia, and a likelihood of delivery by caesarean section (which, in turn, poses a 26-fold increased risk of mortality over vaginal delivery) (A.110:¶17). A diabetic woman exhibiting even slight retinal eye damage is at risk in pregnancy of death or permanent or recurring blindness (A.111: ¶17). Pregnancy may exacerbate the condition of a woman with kidney disease, resulting in the possibility of severe infection, septic shock, and kidney loss (*id.*). Childbirth may accelerate the deterioration of the lung function in a woman with chronic lung disease (A.32: ¶11). A woman with a history of mental health problems, if forced to carry her pregnancy to term, may engage in such self-destructive behavior as self-starvation, self-inflicted injury, and suicide (A.115: ¶4). These examples are far from exhaustive (A.31: ¶9; *see Hodgson v. Board of County Commissioners*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,159 at 10,070 (8th Cir. Jan. 9, 1980); *McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 at 9991-93, 9994-96 (slip op. at 103-16) (E.D. N.Y. Jan. 15, 1980); *Women's Health Services, Inc. v. Maher*, Civ. No. H-79-405, slip op. at 12 (D. Conn. Jan. 7, 1980) (citing "thorough, though not exhaustive, list of 21 conditions," compiled by HEW, that may indicate the medical necessity for an abortion).

In some situations, physicians have more than one choice of treatment for a pregnant woman whose condition is such that she has a medical need for an abortion

(A.108: ¶14). But abortion often remains the "medically preferred choice" (*id.*) for a number of reasons.

First, alternative forms of treatment "are likely to be more radical, less effective, and thus less medically desirable than abortion" (A.117: ¶9). Generally, alternative treatment often poses more dangerous risks of its own. This is particularly true of drug treatment, where remote, adverse consequences often cannot be determined for years (A.108-09: ¶14, citing common use of DES in the 1950's; *see also* A.117: ¶9, drug therapy can harm the fetus; stopping such therapy can endanger the woman's health).

Second, patients with unwanted pregnancies, needing medically necessary abortions, often have neither the will nor the ability to cooperate with special treatment to lessen the abnormal risks of their pregnancies (A.108: ¶14; A.117: ¶9). A drug addict with an unwanted pregnancy, for example, is unlikely to seek out any medical care at all during pregnancy (A.130: ¶9). "In considering whether an abortion were 'medically necessary' for such a woman, a physician would have to weigh the possibility that she could terminate her drug use and receive regular medical attention against the actual likelihood that she would do so" (*id.*; *see McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 at 9993 (slip op. at 111) (E.D. N.Y. Jan. 15, 1980)).

Finally, alternative treatment at best can only somewhat increase a woman's chance of avoiding adverse health consequences. It can rarely render an abnormal risk normal, "because the course of a patient's illness is neither altogether controllable nor altogether predictable" (A.130: ¶10).

F. The Effect Of Illinois' Abortion Funding Restrictions On Indigent Pregnant Women And Teen-Agers.

Pregnancy poses greater health risks to more members of particular populations than to women in general (A.34-37: ¶s15-17; A.107-08: ¶13; A.117-18: ¶s10-11; A.126-27: ¶6(c); A.130-31: ¶11; R.21: Apps. 3-6). Adolescent females are such a high-risk group (A.35: ¶16; A.126: ¶6(c)). Complications of pregnancy and childbirth are from 9 to 25% more frequent for members of this group than for women between the ages of twenty and twenty-four (A.35: ¶16). Pregnant adolescents are more prone to develop anemia and malnutrition (*id.*), to suffer from toxemia and pre-eclampsia (A.126: ¶6(c)), and to require surgical intervention and caesarean section for delivery (*id.*; A.35: ¶16; *see* A.108: ¶13; A.118: ¶11; R.21: Apps. 4-6; *see also McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 at 9999-10,003 (slip op. at 133-50) (E.D. N.Y. Jan. 15, 1980)).

Poverty is the common denominator of recipients of the Illinois medical assistance programs. Poor women have a much higher maternal mortality rate than do women generally (A.36: ¶17; A.130: ¶11; R.21: App. 2 (Table 1)). A greater proportion of poor women have, or develop during pregnancy, certain medical problems than occur among the female population generally. Such problems, when they affect poor women, are more serious than when they affect other women (A.36: ¶17; A.107-08: ¶13; A.117-18: ¶10; A.130-31: ¶11; *see McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 at 9990-91 (slip op. at 101-03) (E.D. N.Y. Jan. 15, 1980); *Women's Health Services, Inc. v. Maher*, Civ. No. H-79-405, slip op. at 13 (D. Conn. Jan. 7, 1980)). These conditions include anemia, malnutrition (especially protein depletion), rheumatic heart disease, essential

hypertension, and sickle cell disease, the last being almost unique to the black population (A.36-37: ¶17; A.107-08: ¶13; A.131: ¶6). Statistically, poor women are more likely than non-poor women to suffer mental health problems from unwanted pregnancy (A.117: ¶10). There is a higher incidence of depressive illness and a higher rate of hospitalization for mental illness among the poor (*id.*). Poverty thus exacerbates the risks of childbirth. It also lessens the practical value of alternative treatments for women with a medical need for abortion.

Poor women also have less access to alternative treatment for high risk pregnancies. Pregnancy and childbirth create a far greater health risk for a woman with a moderate health-threatening condition who is unable to get extra bed-rest than for a woman with the identical condition who is able to do so (A.36: ¶17). But bed-rest may be impossible for poor women who cannot afford to leave badly needed jobs* or to obtain outside help with chores or children (A.36: ¶17; A.118: ¶10).

For the same familial and job reasons which make simple bed-rest unavailable, poor women may not be able to make frequent visits to doctors. Because they are more likely to be under stress generally, they are less able to cope with medical problems (A.117: ¶10). They have less access to medical facilities treating such special risks and are less likely to seek medical care before they suffer acute need (A.118: ¶10). And for those who are willing and able to make such visits, adequate medical facilities are often unavailable—even in the

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* In approximately 24,000 Illinois AFDC recipient families, the mother is employed. DHEW, AID TO FAMILIES WITH DEPENDENT CHILDREN, 1975 RECIPIENT CHARACTERISTICS STUDY: PART 3, at 15 (1978).

Chicago area, where the majority of Illinois medical assistance program recipients reside (A.131: ¶11; A.108: ¶13; A.37: ¶17; A.118-19: ¶10; R.21: App.3). A poor woman with a pregnancy necessitating special medical care will probably fare far worse than other women: she will be less able to get either the mental health or prenatal care that she needs, and she may have to give up needed employment and thereby be without financial resources to care for herself and her family (A.118: ¶10; *see McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 at 9996 (slip op. at 121-22) (E.D. N.Y. Jan. 15, 1980)).

A poor woman will be unlikely to have or be able to get the funds necessary to obtain a medically necessary abortion. For the overwhelming majority of such women, the cost of a legal abortion may well exceed the monthly cash welfare grant provided for their families' non-medical subsistence needs (*i.e.*, food, clothing, shelter) (R.17: p.28n., Exh.L).* Before passage of P.A. 80-1091, defendant Miller's predecessor stated that it "would effectively result in the denial of a medical procedure, abortion, to low-income persons who depend on public assistance programs for payment of medical bills" (R.8: Exh.A).* *See generally, McRae v. Secretary of*

* Those payments are already, in certain respects, below need for non-medical assistance items. *Illinois Welfare Rights Organization v. Trainor*, 438 F.Supp. 269 (N.D. Ill. 1977). Only 22 state plans (of 54) even purport to pay 100% of the state-established standard of need to AFDC recipients without other income. DHEW, CHARACTERISTICS OF STATE PLANS FOR AID TO FAMILIES WITH DEPENDENT CHILDREN UNDER THE SOCIAL SECURITY ACT TITLE IV-A: NEED ELIGIBILITY ADMINISTRATION, 234-35 (1978).

** In New Jersey, during a period when a life-endangerment funding restriction similar to Illinois' was in effect, births to Medicaid-eligible women increased by 30%, while the number

(Footnote continued on following page)

HEW, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 at 9983-84, 10,005 (slip op. at 75-77, 158) (E.D. N.Y. Jan. 15, 1980); *Women's Health Services, Inc. v. Maher*, Civ. No. H-79-405, slip op. at 13-14 (D. Conn. Jan. 7, 1980).

Plaintiff Jane Doe was an indigent pregnant woman whose condition made an abortion medically necessary. At the time she joined this lawsuit, Jane Doe was thirty-eight years old, had had nine previous pregnancies and had a history of varicose veins and thrombophlebitis (A.93-94: ¶s5A, 5B). Continuation of her pregnancy would have resulted in a recurrence of her varicose veins, requiring surgery for their removal (A.92: ¶2). It would also have posed a significant risk of deep vein thrombophlebitis, a medical condition that impairs circulation and requires prolonged hospitalization and bed-rest (*id.*). But bed-rest was simply unavailable to a woman like Jane Doe with small children, subsisting on public assistance (A.130: ¶9). An abortion was medically necessary for her, though not necessary to preserve her life (A.92: ¶3; *see* A.110: ¶17).

Jane Doe's total monthly income for herself and her four dependent children was $374 (A.93: ¶5A; R.17: Exh.L). She wished to terminate her pregnancy (A.89: ¶2), but because of her indigency Jane Doe was unable to secure a safe and legal abortion unless such an abortion was funded under the medical assistance program (A.90: ¶3).

Even assuming that some of these women could borrow or otherwise obtain the funds for legal abortions,

Footnote continued
of Medicaid-funded abortions dropped from over 900 per month to under 25 per month. *Right to Choose v. Byrne*, 398 A.2d 587, 594 (N.J. Super. 1979). *See Women's Health Services, Inc. v. Maher*, Civ. No. H-79-405, slip op. at 13 (D. Conn. Jan. 7, 1980).

the delay in obtaining the money would itself be harmful. "Time of course, is critical in abortion. Risks during the first trimester are admittedly lower than during the later months." *Doe v. Bolton*, 410 U.S. 179, 198 (1973). *See Women's Health Services, Inc. v. Maher*, Civ. No. H-79-405, slip op. at 14 (D. Conn. Jan. 7, 1980); *McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 at 9979-83 (slip op. at 62-72) (E.D. N.Y. Jan. 15, 1980). For women with health problems, delay in obtaining abortion may have even more serious consequences than it would have for healthy women (A.105: ¶ 9).

SUMMARY OF ARGUMENT

I.

A. These appeals present no dispute between adverse parties over the constitutionality of the Hyde Amendment. Accordingly, there is no Article III case or controversy here respecting the constitutionality of the Amendment, and this Court is without jurisdiction to resolve that question on these appeals. *See Muskrat v. United States*, 219 U.S. 346 (1911).

B. This Court nonetheless has appellate jurisdiction under 28 U.S.C. § 1252 over appellants' appeals from the district court's judgment holding that the Illinois statutory abortion funding policy violates the fourteenth amendment. *See McLucas v. DeChamplain*, 421 U.S. 21, 31-32 (1975). Moreover, whatever the contours of this Court's discretion not to review such additional questions otherwise properly before it, the reasons advanced by the United States (U.S. Br. 26-29) argue persuasively against the exercise of such discretion here,

particularly in light of this Court's setting arguments in *Harris v. McRae*, No. 79-1268, in tandem with those here (Order, Feb. 19, 1980).

II.

A. This Court lacks appellate jurisdiction over the appeals of Illinois (No. 79-5) and the intervenors (No. 79-4) on the statutory issues resolved, and relief granted, by the earlier court of appeals' decision. Neither appellant ever took a timely and proper appeal from that decision.

B. Despite the failure of Illinois and the intervenors properly to appeal statutory issues, this Court can and should consider such issues in this case to avoid the fourteenth amendment question presented. The scope of the statutory issues before the Court depends on whether the court of appeals' judgment was final.

If the court of appeals' judgment was not final, then the question of whether Title XIX, standing alone, requires coverage of medically necessary abortions, and the question of whether the Hyde Amendment relieves states of that responsibility are both properly before the Court as providing in combination an alternative ground for affirming the district court's judgment.

If the court of appeals' judgment was final, it would be *res judicata* and preclude either question from being considered here, except insofar as parties properly sought review of such questions and review is granted. In this circumstance, the principle of avoiding unnecessary constitutional adjudication should be satisfied by granting appellees' Conditional Petition for Certiorari (No. 79-64) to reach the question presented there: whether the Hyde Amendment operated substantively to amend Title XIX.

While the question is not free from doubt, the better view is that the court of appeals' judgment was not final. *See Mathews v. Eldridge*, 424 U.S. 319, 331n.11 (1976); *Catlin v. United States*, 324 U.S. 229, 233 (1945).

III.

A. The district court held that Illinois' withdrawal of medical assistance coverage of medically necessary abortions is unconstitutional. That judgment should be affirmed either on the ground adopted by the district court—failure rationally to further a legitimate state interest—or because the stricter "compelling state interest" test is appropriately applied here where Illinois penalizes exercise of a woman's fundamental rights.

The compelling state interest test is applicable because Illinois discriminates, in the context of its otherwise comprehensive programs of medically necessary care for the poor, against a woman's exercise of her fundamental right of privacy in the abortion decision. The fundamentality of the woman's right in that decision is well established in the decisions of this Court. *E.g., Roe v. Wade*, 410 U.S. 113 (1973); *Colautti v. Franklin*, 439 U.S. 379 (1979). That the discrimination comes in the form of withdrawing funding has never been held either to legitimate that discrimination or to obscure the fact that it is a fundamental right that is disfavored. *Maher v. Roe*, 432 U.S. 464 (1977), says nothing to the contrary, since there was no relevant discrimination in that case. The state there was withholding funding for elective abortions, as it did for other elective procedures.

Illinois' discrimination is both intended to stop as many abortions as possible and is an effective means to

do so, since many indigent women will have no access to funds to obtain medically necessary abortions privately. Others will obtain such abortions only after dangerous delay. This clearly makes it a "penalty" on exercise of fundamental rights. *Memorial Hospital v. Maricopa County*, 415 U.S. 250 (1974); *Shapiro v. Thompson*, 394 U.S. 618 (1969).

B. Regardless of the equal protection standard used to test Illinois' action, the conclusion of unconstitutionality is required, since Illinois' actual purpose was the illegitimate one of preventing indigent women from obtaining medically necessary abortions. The affirmative and effective intent to stop women from exercising their fundamental constitutional rights makes Illinois' action a violation of the rights of those women to due process of the law as well as to equal protection. Illinois cannot rationalize its action as an expression of taxpayer moral judgment, since constitutional constraints exist precisely to prevent taxpayers from using governmental power to impose values they are perfectly free to pursue as individuals. *Epperson v. Arkansas*, 393 U.S. 97 (1968); *United States Department of Agriculture v. Moreno*, 413 U.S. 528 (1973).

The state could have no legitimate interest in childbirth that is abnormal. *Doe v. Bolton*, 410 U.S. 179 (1973); *Maher v. Roe*, 432 U.S. 464 (1977); *Beal v. Doe*, 432 U.S. 438 (1977). Nor could it have any legitimate interest in protecting potential life or in altering state demographics if that is accomplished through the sickness and deaths of unwilling indigent pregnant women.

The state was not seeking to prevent fraud, which is dealt with otherwise in its medical assistance programs by methods that do not damage recipients' health and threaten their lives. The state was not trying to prevent

doctors from making medically misguided decisions, and this Court's decisions forbid states from rationalizing anti-abortion measures in such terms. *E.g., Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976). The state was not trying to save money, since refusal to fund medically necessary abortions costs the state a substantial amount of money.

Even if these fictitious purposes were available to Illinois as justification, they would not help the Illinois statute withstand constitutional scrutiny. None of them is compelling in the pre-viability stage of pregnancy; and none of them is even rationally served by Illinois' reckless willingness to sacrifice the actual lives of some indigent pregnant women, the actual health of many others, the privacy interests of all women in making the abortion decision for themselves, and substantial state funds. This Court does defer to many state allocative decisions in social welfare programs, when factors such as the pregnant woman's health and privacy are not involved, as they are here. *See Dandridge v. Williams*, 397 U.S. 471 (1970). But Illinois' action here does not allocate scarce funds among competing uses. Illinois' action costs the state money and thus exacerbates other allocative dilemmas in social welfare programs. Any reason for special deference to certain state welfare classifications is missing.

IV.

A. Illinois provides to all Medicaid recipients all medically necessary services, including physicians' and hospital services, with the exception of medically necessary abortion services. Title XIX of the Social Security Act requires Illinois to provide for the inclusion of "at least" a defined minimum benefit package, including hospital and physicians' services, for eligible recipients. 42 U.S.C. § 1396a(a)(13), d(a) (1976). Such services also must be of high quality and provided in a manner consistent with the best interests of recipients. 42 U.S.C. § 1396a(a)(19), (22)(D) (1976). Nothing in the Medicaid statute qualifies the duty to provide medically necessary mandatory services. These provisions make Illinois' exclusion of medically necessary abortions invalid under Title XIX.

The 1972 amendments to the Social Security Act, creating Professional Standards Review Organizations (PSROs), established medical necessity as the Medicaid coverage standard for hospital, physicians' and other services. Act of Oct. 30, 1972, Pub. L. No. 92-603, 86 Stat. 1429 (amended 1977) (codified at 42 U.S.C. § 1320c *et seq.*). The 1972 amendments require PSROs, rather than state Medicaid agencies, to determine whether services are medically necessary and therefore covered by Medicaid, or are unnecessary and therefore uncovered. *Id.* The medical necessity standard is the one which doctors commonly apply, and it is grounded firmly in the Medicaid statute and in this Court's decisions. *Doe v. Bolton*, 410 U.S. 179, 192 (1973); *Beal v. Doe*, 432 U.S. 438, 441-42n.3 (1977).

The Medicaid statute and implementing regulations of the Department of Health Education and Welfare (HEW) (*see* 42 C.F.R. § 440.230 (1979)) also prohibit Illinois from denying medically necessary services on the basis of a restrictive standard applied only to recipients suffering from particular conditions. Those provisions of the statute and regulations permitting certain across-the-board limitations on services for fiscal reasons are inapplicable. Illinois' refusal to fund medically necessary abortions is not evenhanded, and it costs the state

money. The Illinois policy subjects women to great damage to their health, and jeopardizes their lives; as such it is antithetical to the purposes of Medicaid.

The effect of the Hyde Amendment aside, HEW has taken the position that states must, under Title XIX, cover medically necessary abortion services. The same conclusion has been reached in twelve federal court rulings, including those of four courts of appeals. That conclusion is compelled by the statute, the legislative history, and HEW regulations.

B. The court of appeals held that the Hyde Amendment was intended to amend Title XIX substantively so as to permit Illinois to deny medically necessary abortion services the Act would otherwise require it to cover. This is erroneous. It has provoked a variety of responses from appellants, none of which supports the court of appeals' position, and none of which is correct.

Nothing on the face of the Hyde Amendment suggests that Congress meant to do anything other than limit federal reimbursement to a state for services Title XIX requires a state to cover as a condition of federal support generally for its Medicaid program. Following the language of the Amendment produces no anomalous result, and recourse to legislative history is thus unnecessary. *TVA v. Hill*, 437 U.S. 153, 184n.29 (1978).

The pattern of disagreement among appellants and the court of appeals demonstrates how precarious it is to try to infer anything from the Hyde Amendment's legislative history. If recourse to legislative history is appropriate, moreover, it supports neither the court of appeals' analysis nor that of any appellant. The root fallacy of the varying arguments that the Hyde Amendment altered the coverage requirements of Title XIX is

that they equate the anti-abortion sentiment of a majority of legislators with a directed intent to take a specific anti-abortion action which neither the measure before them nor legislators speaking on its behalf specifically expressed. This Court should hesitate to ascribe such far-reaching action to Congress' silence respecting any intent to alter a substantive statute when the consequences of that action would damage health in a program intended to promote it.

The United States argues that Medicaid, as a scheme of cooperative federalism, so thoroughly intertwines federal matching funds with requirements imposed on the states that the suspension of federal funds for a particular aspect of the program necessarily, albeit *sub silentio*, suspends the programmatic requirements. The argument that every specific coverage requirement of Title XIX is linked to federal funding for that requirement is, however, false in fact and contrary to HEW's previously consistent position.

While a state's general participation in Medicaid is induced by federal funding in the aggregate, nothing ties each specific service requirement to federal funding. There are many examples—under Medicaid specifically as well as under other programs established under the Social Security Act—of substantive requirements imposed by Congress on the states without federal matching funds. Considered individually and cumulatively these examples foreclose any attempt to distinguish the Hyde Amendment from other federal funding cut-offs that leave programmatic requirements unaffected.

V.

If this Court should reach the question in these appeals of the constitutionality of the Hyde Amendment construed as a substantive amendment of Title XIX, the standards for testing its constitutionality are essentially equivalent to those applicable under the fourteenth amendment. *Weinberger v. Wiesenfeld*, 420 U.S. 636 (1975). Since Illinois' action is unconstitutional, the Hyde Amendment would then be unconstitutional as well.

ARGUMENT

I.

THIS COURT HAS APPELLATE JURISDICTION OVER THE PRESENT APPEALS UNDER 28 U.S.C. § 1252 BUT LACKS JURISDICTION TO RESOLVE THE CONSTITUTIONALITY OF THE HYDE AMENDMENT.

A. There Is No Case Or Controversy As To The Constitutionality Of The Hyde Amendment.

Appellees have never sought any injunctive or declaratory relief against the Hyde Amendment. They need no such relief, and no holding on its constitutionality can alter the appellees' rights under the district court's judgment on the constitutionality of the Illinois statute.* Accordingly, this Court has no jurisdiction to

* The Hyde Amendment's constitutionality was injected into the case by the court of appeals, *sua sponte*. *See* Petition for Cert. 25-26. By virtue of the district court's injunction against Illinois officials, appellees currently enjoy the full relief they seek; the outstanding declaration of unconstitutionality of the Hyde Amendment gives them no additional relief. The issue of the constitutionality of the Hyde Amendment is no more necessary to resolution of this case than it was to resolution of *Maher v. Roe*, 432 U.S. 464 (1977), where it was not mentioned.

decide the Hyde Amendment's constitutionality. *See* Appellees' Motion to Vacate in Part ...., Nos. 79-4, 79-5, 79-491 ("Motion to Vacate") at 6-9; *see also* Conditional Petition for Writ of Certiorari, No. 79-64 ("Petition for Cert.") at 25-26. The United States agrees with this position (U.S. Br. 26-29).

Appellant Miller ("the State" or "Illinois") disagrees, but does so with arguments that have no bearing on the question. He cites the "essential relatedness of the state and federal limitations on abortion funding" (St. Br. 25), referring to (1) appellees' federal statutory claim which turns, in part, on construction of the effect of the Hyde Amendment (*id.* at 21-22); (2) the extent to which the Illinois legislature may have been "aware of, and motivated by" passage of the Hyde Amendment (*id.* at 22); and (3) the asserted identity of the statutes and the constitutional standards by which they are to be judged (*id.* at 23, 23n.10, 25). To establish the requisite case or controversy, however, Illinois must show that there is a concrete dispute between adverse parties with respect to the Hyde Amendment's constitutionality. *Muskrat v. United States*, 219 U.S. 346 (1911). Appellees' federal statutory claim, the motivation of the Illinois legislature in passing P.A. 80-1091, and the asserted parallelism of constitutional issues do not make a legally sufficient dispute on the question of the Hyde Amendment's constitutionality.

The State also relies on *appellants'* motions for summary judgment that the Hyde Amendment is constitutional (R.98, 106, 107), and its own motion to require the United States to reimburse Illinois for all medically necessary abortions.* None of these motions

* This motion, filed after the district court's judgment on the merits, was entered and continued as not ripe for decision (R.124).

shows any dispute about the Hyde Amendment's constitutionality. The grounds on which the State sought reimbursement were that to require the state alone to fund medically necessary abortions would be "inequitable" and violative of Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* (1976 & Supp.I 1977) ("Title XIX" or "the Medicaid Statute") (A.144), not that the Hyde Amendment was unconstitutional. The United States and Illinois agree that the Hyde Amendment is constitutional. Their agreement dispels any notion that there is an Article III case or controversy about the constitutionality of that provision between those two parties. *Moore v. Charlotte-Mecklenburg Board of Education*, 402 U.S. 47, 48 (1971).

B. This Court Has Jurisdiction To Review The Remainder Of The District Court's Judgment, And It Should Do So.

The district court's judgment of unconstitutionality embraced not only the Hyde Amendment, but Illinois' statutory abortion coverage policy. Both Illinois and the intervenors (though not the United States) appealed the court's ruling that the Illinois policy violates the fourteenth amendment (A.146, 151, 154). No party contests the appellate jurisdiction of this Court over the fourteenth amendment question; and power to review that question is clear. *McLucas v. DeChamplain*, 421 U.S. 21, 31-32 (1975).

The United States argues, however, that where appellate jurisdiction under 28 U.S.C. § 1252 (1976) is predicated upon a constitutional ruling rendered by a lower federal court without jurisdiction to review the validity of the federal statute in question, this Court should not, in the usual case, proceed to decide the other questions before it in the appeal. This view is without

support in the case law. The United States' argument reflects an admirable desire to further the policy of minimizing the burden of this Court's mandatory docket. In *McLucas v. DeChamplain*, 421 U.S. 21, 32 (1975), however, this Court observed that "in § 1252 Congress unambiguously mandated an exception to this policy in the narrow circumstances the section identifies," and emphasized that "an appeal under § 1252 brings before us, not only the constitutional question, but the whole case . . . ." The Court there proceeded to resolve all the substantive questions presented on that appeal, notwithstanding a substantial jurisdictional question about whether the district court had properly addressed the federal constitutional question on which the appeal under section 1252 had been predicated.*

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* The United States relies on *FHA v. Darlington*, 352 U.S. 977 (1957), in which a single district judge enjoined a federal statute as unconstitutional. On the United States' appeal, this Court, without reaching the merits, ruled that a three-judge district court should have been convened; it therefore reversed the judgment of the single judge and remanded for further proceedings. 352 U.S. at 977-78. Unlike *Darlington*, however, there is no question here of the district court's jurisdiction over the claims appellees urge this Court to review. More to the point is *United States v. Raines*, 362 U.S. 17 (1960). In *Raines*, the district court held a federal statute unconstitutional. The United States appealed under § 1252, and this Court found that the decision had been "exercised with reference to hypothetical cases," 362 U.S. at 22, so that it was not premised on a justiciable case or controversy. *Id.* at 20-26. This Court then proceeded to review other questions presented as alternative grounds for affirming the district court's ruling, suggesting that the propriety of its doing so turned on whether the district court had "expressed its views" on them, which it had. *Id.* at 27n.7. In this case, of course, the district court not only "expressed its views" on the constitutionality of the Illinois policy, but its decision was almost entirely restricted to analysis of it, rather than of the Hyde Amendment.

The United States in the end urges this Court to address the fourteenth amendment question before it, as well as aspects of the court of appeals' statutory ruling (U.S. Br. 36-38). Whatever the contours of this Court's discretion not to review the questions presented in section 1252 appeals,* the reasons advanced by the United States argue persuasively against the exercise of such discretion here. Indeed, any doubt that this Court should address these additional issues would appear to have been resolved by developments since the United States filed its brief. In *McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 (E.D.N.Y. Jan. 15, 1980), the district court enjoined the Hyde Amendment as unconstitutional. The Secretary of HEW appealed, and appellees in *McRae* moved this Court to schedule arguments in tandem with arguments in these appeals. In their motion, they urged that only arguments in tandem could assure resolution of the "distinct but interrelated issues posed by federal *and state* restrictions on medicaid reimbursement for abortion," and "guarantee a comprehensive resolution" of the "abortion funding controversy." Motion to Schedule Arguments in Tandem at 1, 5 (emphasis added). This

* A direct appeal to this Court under § 1252 is the exclusive appellate remedy for all parties when a lower federal court has ruled a federal statute unconstitutional (regardless of what questions they wish to appeal), *see* 28 U.S.C. §§ 1252, 1291 (1976) and U.S. Br. 27n.14. Accepting this argument of the Solicitor General thus would make this Court an interim forum required to "clean up" such cases before an appeal on the merits. This would entail substantial delay in the ultimate disposition of the issues presented in § 1252 appeals, in circumstances under which the parties are required to bring their appeals to this Court in the first instance and where, as here, all questions may have been fully briefed and argued in this Court. This would, in effect, cause that splitting of appeals which the Solicitor General urges be avoided (U.S. Br. 35).

Court granted that motion. *Harris v. McRae*, No. 79-1268 (Order, February 19, 1980).

II.

THIS COURT LACKS APPELLATE JURISDICTION TO REVIEW THE APPEALS OF ILLINOIS AND THE INTERVENORS ON STATUTORY ISSUES, BUT SHOULD REVIEW STATUTORY CLAIMS WHICH PROVIDE ALTERNATIVE GROUNDS FOR AFFIRMING THE DISTRICT COURT JUDGMENT.

The court of appeals ruled that, under the federal Medicaid statute, Illinois must fund all abortions for which the Hyde Amendment provides federal funding. *Zbaraz v. Quern*, 596 F.2d 196 (7th Cir. 1979) ("*Zbaraz II*," at U.S.J.S. App. 74a). The intervenors have purported to invoke 28 U.S.C. § 1252 to secure review of that decision, as well as of the district court judgment (A.148; Intervenors' J.S. 23-25). The State never sought review of any aspect of the court of appeals' decision. Nonetheless it now urges this Court to consider "all . . . statutory questions which were before the Court of Appeals" (St. Br. 31).

Appellees have moved to dismiss the intervenors' appeal insofar as it seeks review of the court of appeals' decision herein, principally on the ground that intervenors never took a timely appeal from that decision—or indeed any appeal at all—within the meaning of the Rules of this Court or of 28 U.S.C. § 2101 (*see* Motion to Vacate 26-28). Intervenors argue that the court of appeals' decision was interlocutory and, therefore, this Court, on appeal, can reach back and correct errors in an interlocutory decision (Int. Br. 5). The United States reviews the reasons (previously outlined in our Motion to Vacate 29-30) why the statutory decision intervenors seek to challenge is not included within the

district court judgment (U.S. Br. 39-40). Whether interlocutory or not (*see* pp. 35-37 *infra*), the court of appeals' judgment on the statutory questions was never merged into the only judgment that intervenors properly appealed: that of a district court for which the court of appeals judgment on such questions was conclusive, and which therefore went on to consider separate legal issues.*

The State's argument supporting its belated** attempt to secure review of the court of appeals decision is equally insubstantial. Illinois relies on a "whole case" argument already addressed in appellee's Motion to Vacate and in the United States' Brief.*** Illinois also refers to

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* The cases on which the intervenors rely to support their argument (Int. Br. 5) are therefore inapposite; each confirmed this Court's unquestioned power to review a final judgment of a court of appeals into which is merged an earlier interlocutory decision of that court.

** S. Ct. R. 15(c) provides that "[o]nly the questions set forth in the jurisdictional statement or fairly comprised therein will be considered by the court." *See Phillips Chemical Co. v. Dumas Independent School Dist.*, 361 U.S. 376, 386 (1960). Illinois never set forth in its jurisdictional statement any statutory questions.

*** Illinois' reliance on this doctrine is not legitimated by this Court's expansive interpretation of 28 U.S.C. § 1252. *Compare* St. Br. 29-30. This Court's reading of § 1252 has never even hinted at the proposition that this Court has appellate jurisdiction to review judgments not appealed. *Farmers & Mechanics Nat'l Bank v. Wilkinson*, 266 U.S. 503 (1925), and other cases on which appellees rely (*see* Motion to Vacate 30-33) are not distinguishable because they were decided under jurisdictional provisions allowing for direct appeal in a much broader class of cases than is embraced by 28 U.S.C. § 1252 (*see* St. Br. 29-30). *Farmers & Mechanics Nat'l Bank* and its predecessors were not predicated upon any professed need to limit this Court's appellate docket. The principle governing their disposition was, rather, that review of a court of appeals' decision could not be secured by recourse to jurisdictional provisions which there permitted review only of district court decisions.

the principle of avoiding unnecessary constitutional adjudication (St. Br. 26-27, 30). The concern to avoid constitutional questions is certainly appropriate, but hardly excuses the failure by appellants to invoke this Court's jurisdiction in the proper way (*see* Motion to Vacate 25-33). This Court can avoid constitutional questions only when it has an alternative ground for decision properly before it. A properly filed notice of appeal or petition for certiorari from the court of appeals' decision is a jurisdictional prerequisite for this Court's review of that judgment. Moreover, the State seeks review of statutory issues, which it previously lost, to *enhance* the possibility of this Court's consideration of the constitutional question presented, not to avoid it. There is no jurisdictional basis on which this Court might consider the appellants' appeals on the statutory issues and their attempts to reverse the relief obtained by appellees in the court of appeals.

Despite appellants' failure to appeal statutory issues properly, this Court can and should consider such issues in this case to avoid the fourteenth amendment question presented. The court of appeals held that Title XIX, standing alone, requires coverage of medically necessary abortions, but that the Hyde Amendment alters Title XIX so as largely to relieve the states of that obligation. Whether this Court is to consider the statutory Hyde Amendment issue alone, or both of these statutory issues, turns on resolution of the complex question, not addressed by any appellant, of whether the court of appeals' judgment was final.

If the court of appeals' judgment was not final, then the questions of whether Title XIX, standing alone, requires the states to fund medically necessary abortions and whether the Hyde Amendment relieved them of

that obligation are both properly before the Court as providing an alternative ground for affirming the district court's judgment. It is on this assumption of non-finality that appellees address both of these statutory questions in Section IV, *infra*.

If the court of appeals' judgment was final, it would be *res judicata* and preclude any statutory questions decided by that court from being considered here, except insofar as parties properly sought review of such questions and review is granted. *See Huron Holding Co. v. Lincoln Mine Operating Co.*, 312 U.S. 183 (1941) (pending appeal does not suspend finality).* The principle of avoiding unnecessary constitutional adjudication, however, could and should still be satisfied in this case by granting appellees' Conditional Petition for Certiorari (No. 79-64), prior to or simultaneously with a decision on the merits, to consider the statutory question presented in the petition (Hyde Amendment's effect on Title XIX). *Cf. Palmer v. United States*, 411 U.S. 389, 396-97 (1973) (granting certiorari as to one of two questions appealed, when appeal has been improvidently taken). Resolution of this question (addressed in Section IV.C, *infra*)

* While the judgment was not *res judicata* as to the United States because it was not yet a party when this case was in the court of appeals, the United States has no standing to litigate the statutory issues. The United States intervened in this case pursuant to 28 U.S.C. § 2403, under which it is "permit[ted] . . . to intervene . . . for argument on the question of constitutionality," of the "Act of Congress . . . drawn in question," not other questions also presented in the litigation. *See Smolowe v. Delendo Corp.*, 36 F.Supp. 790, 792 (S.D.N.Y. 1940); R.104: p. 1; U.S.J.S. 2; *cf.* S. Ct. R. 15(c). Moreover, appellees have never sought any relief against the United States on any claims, including the statutory ones. Petition for Cert. 25; Motion to Vacate 6. Therefore the presence of the United States as a party appellant in this Court does not affect the extent to which this Court may address the statutory issues.

favorably to appellees would make a decision on their constitutional claim unnecessary.

The United States at one point appears to assume that the court of appeals judgment was final (U.S. Br. 41, asserting that intervenors could have appealed the court of appeals decision under 28 U.S.C. § 1254 (2), and thus suggesting that that ruling was final. *See South Carolina Electric & Gas Co. v. Flemming*, 351 U.S. 901 (1956); *Slaker v. O'Conner*, 278 U.S. 188 (1929)). The case law does not on balance support, and seems to contradict, that assumption. *See Mathews v. Eldridge*, 424 U.S. 319, 331n.11 (1976); *Catlin v. United States*, 324 U.S. 229, 233 (1945); *Cobbledick v. United States*, 309 U.S. 323, 324 (1940); *see also Corey v. United States*, 375 U.S. 169 (1963); *Hudson Distributors, Inc. v. Lilly & Co.*, 377 U.S. 386, 397-98 (1964) (Harlan, J. dissenting); *but see Cox Broadcasting Corp. v. Cohn*, 420 U.S. 469, 476-87 (1975).

III.

ILLINOIS' DISCRIMINATION AGAINST WOMEN REQUIRING MEDICALLY NECESSARY ABORTIONS DEPRIVES THOSE WOMEN OF RIGHTS UNDER THE FOURTEENTH AMENDMENT.

Illinois may not, consistently with the state's obligations under the fourteenth amendment, withdraw funding for all medically necessary abortions other than those necessary to preserve the pregnant woman's life, while continuing to fund essentially all other medically necessary procedures under its comprehensive medical assistance programs.* The district court found, on the basis of an unequivocal record, that the Illinois dis-

* The Final Judgment and Order that is the subject of this appeal defines a "medically necessary abortion" as:

> an abortion which is necessary for the preservation of the life or the physical or mental health of a woman seeking such treatment, in the professional judgment of a licensed physician in Illinois, exercised in light of all factors relevant to her health.

U.S.J.S. App. 24a. That definition was adopted from *Doe v. Bolton*, 410 U.S. 179, 192 (1973); *see also Colautti v. Franklin*, 439 U.S. 379, 387-88 (1979); *Beal v. Doe*, 432, U.S. 438, 441-42 n.3 (1977). The federal statutory obligation to include medically necessary care generally, without distinction on the basis of diagnosis or condition, is discussed at length at pp. 73-99 *infra*. The State characterizes the Illinois medical assistance programs as "non-comprehensive" (St. Br. 66). The characterization is accurate insofar as Illinois generally excludes care which is not medically necessary (*see* p. 6 *supra*). The characterization is inaccurate if it is meant to suggest that Illinois in fact excludes medically necessary procedures other than abortion (*see* pp. 5-6 *supra*). Its treatment of medically necessary abortions aside, if Illinois does exclude a type of medically necessary care from a category of care covered under its Medicaid program, then it is acting in contravention of the Act (*see* pp. 73-99 *infra*). Illinois' exclusion of medically necessary abortions from coverage is permissible under Title XIX only if the Hyde Amendment implicitly amends the substantive provisions of the Act (*see* pp. 99-130 *infra*).

crimination subjects a pregnant woman "to considerable risk of severe medical problems, which may even result in her death," and that "the effect of the [Illinois] criteria . . . will be to increase substantially maternal morbidity and mortality among indigent pregnant women.' (U.S.J.S. App. 17a.)*

The Illinois statute came in the wake of this Court's decision in *Maher v. Roe*, 432 U.S. 464 (1977), and appellants throughout this litigation have relied almost exclusively on *Maher* and the companion decision of *Poelker v. Doe*, 432 U.S. 519 (1977), to argue that discrimination with the devastating effects the district court found is constitutional. What appellants consistently brush aside, however, is that the health considerations that are central in this case were missing entirely from *Maher* and *Poelker*. *See* pp. 44-46 *infra*. The most persistent theme in this Court's abortion decisions has been the primacy of the woman's health. *Roe v. Wade*, 410 U.S. 113 (1973), made clear that an interest in the woman's health is one the state can attempt to *further* with proper regulation after the first trimester of pregnancy. Indeed, at that point the state's interest in the woman's health becomes "compelling." 410 U.S. at 163. But *Roe* makes clear—and not a word in a single abortion decision of this Court since *Roe* even hints at disagreement—that the state cannot further any other interest when the result will be any significant jeopardy to the pregnant woman's health, let alone her life. *Roe v.*

* Under instruction from the court of appeals, the district court was specifically considering the effects of the Illinois statute as modified by injunction to conform to the standard of the Hyde Amendment then in effect. Since the original Illinois standard is even more restrictive than that of the Hyde Amendment, the district court's findings are fully applicable to the more restrictive standard.

Wade, 410 U.S. 113, 163-65 (1973); *see Doe v. Bolton*, 410 U.S. 179, 192 (1973); *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 61, 75-79 (1976); *Colautti v. Franklin*, 439 U.S. 379, 387-88, 394, 400 (1979). *Maher* and *Poelker* are not only consistent with this uncompromised theme, but they reaffirm the overriding importance of the woman's health. 432 U.S. at 472.

On the basis of its findings, the district court held that, for the period prior to fetal viability,* the Illinois discrimination violated the fourteenth amendment's equal protection guarantee because it was not rationally related to pursuit of any "legitimate, articulated state purpose . . . ." *San Antonio Independent School District v. Rodriguez*, 411 U.S. 1, 17 (1973). The court specifically found no legitimate state "interest in preserving the life of a non-viable fetus at the cost of increased maternal morbidity and mortality among indigent pregnant women." (U.S.J.S. App. 18a.)** *Accord, Reproductive*

* Appellees have not appealed from the district court's holding with regard to the very rare post-viability abortions, and hence no issue is posed here with regard to such abortions.

** In following this Court's definitive balance of interests in *Roe*, the district court characterized as illegitimate what this Court had found impermissible. The intervenors object to the district court's terminology (Int. Br. 47), but whatever form of words is used, it is clear that the district court's holding was that Illinois' reckless unconcern with actual maternal life and health is an irrational way to serve any legitimate interest that might be involved. Thus the district court said that "a pregnant woman's interest in her health so outweighs any possible state interest in the life of a non-viable fetus that, for a woman medically in need of an abortion, the state's interest is not legitimate." (U.S.J.S. App. 20a.) In similar fashion this Court found in *Zablocki v. Redhail*, 434 U.S. 374, 388 (1978), that a Wisconsin law had adopted irrational means to pursue

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Health Services v. Freeman, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,160 (8th Cir. Jan. 9, 1980); *Women's Health Services, Inc. v. Maher*, Civ. No. H-79-405 (D. Conn. Jan. 7, 1980); *McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 (E.D.N.Y. Jan. 15, 1980); *Doe v. Percy*, 476 F.Supp. 324 (W.D. Wis. 1979). The district court's decision should be affirmed not only on the ground it employed, but also because the more strict, compelling state interest, standard of review is appropriate here where Illinois has intentionally penalized a woman's exercise of her fundamental rights in making the abortion decision.

A. Illinois' Discrimination Against Women Requiring Medically Necessary Abortions Must Be Subjected To The Compelling State Interest Test.

The first step in application of equal protection analysis here is to decide "'whether [[the] state legislation] . . . impinges upon a fundamental right explicitly or implicitly protected by the Constitution, thereby requiring strict judicial scrutiny . . . .'" *Maher v. Roe*, 432 U.S. 464, 470 (1977). The class of fundamental rights that triggers strict scrutiny is quite limited, but there can be no doubt that the woman's right of privacy in an abortion decision is one of those rights. An interest in procreation was identified as "fundamental" and a "basic liberty" at least as early as *Skinner v. Oklahoma*, 316 U.S. 535 (1942). *Griswold v. Connecticut*, 381 U.S. 479 (1965), articulated important constitutional values in insulating childbearing decision-making from most state involvement. In *Roe v. Wade*, 410 U.S. 113 (1973), this

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interests acknowledged to be "legitimate and substantial." *See Craig v. Boren*, 429 U.S. 190 (1976); *Carey v. Population Services Int'l*, 431 U.S. 678, 715 (1977) (Stevens, J. concurring).

Court identified a "'fundamental' . . . right of privacy . . . founded in the Fourteenth Amendment's concept of personal liberty . . . broad enough to encompass a woman's decision whether or not to terminate her pregnancy." 410 U.S. at 152-53. Since *Roe*, the Court and individual Justices have repeatedly recurred to the fundamentality of childbearing decision-making, including the decision whether to have an abortion. In addition to the consistent rulings in abortion cases, *see San Antonio Independent School District v. Rodriguez*, 411 U.S. 1, 34n.76 (1973); *Cleveland Board of Education v. LaFleur*, 414 U.S. 632, 640 (1974) ("'matters so fundamentally affecting a person as the decision whether to bear or beget a child,'" *quoting Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972)). *Maher v. Roe*, 432 U.S. 464 (1977), referred to "the fundamental right recognized . . . in [*Roe*]," 432 U.S. at 471. *Roe* was again cited in *Zablocki v. Redhail*, 434 U.S. 374 (1978), to show "a fundamental right to seek an abortion . . . ." 434 U.S. at 386. And only last term this Court wrote of a "['fundamental'] right of privacy, implicit in the liberty secured by the Fourteenth Amendment, that is 'broad enough to encompass a woman's decision whether or not to terminate her pregnancy.'" *Colautti v. Franklin*, 439 U.S. 379, 386 (1979). *See also Moore v. City of East Cleveland*, 431 U.S. 494, 499, 531, 536 (1977) (Powell, J. writing for a plurality of four and Stewart, J. dissenting).

The district court rejected applicability of the compelling state interest test, but only because it misapprehended the right asserted. Citing *Maher*, the district court found "no fundamental right to a publicly funded abortion . . . ." (U.S.J.S. App. 12a.) Appellees have never claimed any such fundamental right. The fundamental right is in making the abortion decision, not in the receipt of public funds. Once a state undertakes a

program of public spending, however, the general contours of which cover all medically necessary care, it cannot in implementing that program discriminate against exercise of fundamental rights. That is precisely what Illinois has done here.

In *Shapiro v. Thompson*, 394 U.S. 618 (1969), this Court found the compelling state interest test applicable because of state discrimination in a welfare program against those exercising the fundamental right of interstate travel. This surely did not amount to recognition of a fundamental right to publicly financed travel. Similarly, in *San Antonio Independent School District v. Rodriguez*, 411 U.S. 1 (1973), this Court held that there was no fundamental right to education. But it did so—in the process distinguishing the fundamental right to privacy in the abortion decision, 411 U.S. at 34n.76—only as a preliminary step in determining the level of scrutiny that would be used to test financing discrimination that impinged upon exercise of educational rights. Seldom is there a constitutional right to command public funds. But the equal protection guarantee still forbids discriminatory financing that seriously impinges upon the individual's decision-making with regard to fundamental rights.

In this case, Illinois' general provision of medically necessary procedures defines the discrimination, not the right or interest thereby disfavored. The district court's error in defining the fundamental right at stake seems to have been rooted in a misunderstanding of this Court's discussion of *Shapiro* in *Maher v. Roe*, 432 U.S. 464 (1977). The discussion came in answer to the extreme claim advanced in *Maher*—that the state had an affirmative obligation to finance a woman's exercise of her fundamental privacy right. This Court rejected the analogy to *Shapiro*, saying:

> If Connecticut denied general welfare benefits to all women who had obtained abortions and who were otherwise entitled to the benefits, we would have a close analogy to the facts in *Shapiro*, and strict scrutiny might be appropriate . . . . But the claim here is that the State "penalizes" the woman's decision to have an abortion by refusing to pay for it. *Shapiro* and [the later case of] *Maricopa County* . . . did not hold that States would penalize the right to travel interstate by refusing to pay the bus fares of the indigent travelers. 432 U.S. at 474-75n.8.

What Illinois has done here is precisely analogous to the state action in *Shapiro* and quite unlike the state action in *Maher*.

In a state without a medical assistance program, a request from a pregnant woman to finance an abortion raises no claim of constitutional right, because a state need not affirmatively subsidize exercise of even the most "fundamental" of rights. It is precisely such a claim that this Court was facing in *Maher* and *Poelker*. The plaintiffs there sought medical assistance funding for purely elective abortions.* But there were no

* Appellants and their amici expend considerable effort arguing that *Poelker* involved a claim for state provision of medically necessary, not elective, abortions (*see, e.g.*, St. Br. 66, 81; Int. Br. 28-30; *cf.* U.S. Br. 57).

Maher was the principal case on the constitutional issue decided that day, and it characterizes the abortions under discussion as "non-therapeutic" or "elective" no fewer than ten times. It uses contrasting terms like "medically necessary" at least seven times. The same distinction is explicit in the companion case of *Beal v. Doe*, 432 U.S. 438 (1977). *Poelker* was appended to *Maher* and *Beal* with a short *per curiam* opinion.

The history of *Poelker* does reveal ambiguity on the question of medical justification for an abortion for the plaintiff; the court of appeals noted that she did have some medical

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programs of coverage for elective care (*see* pp. 80-85 *infra*). In the absence of a relevant discrimination, the plaintiffs in *Poelker* and *Maher* had no more claim to state funds for elective abortion than to funds to get them to the polls on election day.

The distinction between elective procedures that the state does not generally fund and medically necessary procedures that the state does fund generally is crucial.*

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problems. *Doe v. Poelker*, 515 F.2d 541, 543 (8th Cir. 1975). But these medical problems were irrelevant to the legal issue as framed by the plaintiff and by the district court. Thus the district court's unreported decision repeatedly characterizes the policy in issue as one that denied abortion "except for medical reasons." Motion To Vacate App. A at 1a.

The certiorari petition in *Poelker* likewise characterized the substantive issue for review as involving a woman's "request for an abortion based on her financial distress within her first trimester of pregnancy *where no medical indications exist.*" Petition for Certiorari 4, in *Poelker v. Doe*, 432 U.S. 519 (1977) (emphasis added). This Court's *per curiam* opinion then meticulously avoided joining any factual dispute about the medical necessity of an abortion for the *Poelker* plaintiff. 432 U.S. at 520n.1. It equated the *Poelker* and *Maher* issues, and characterized the common issue as involving "nontherapeutic abortions." 432 U.S. at 521. As the district court concluded below, this Court in *Poelker* "could not have intended . . . to obliterate the distinction it had carefully drawn in *Maher* between medically necessary and nontherapeutic abortions." U.S.J.S. App. 16a, n.9; *see Doe v. Percy*, 476 F.Supp. 324 (W.D. Wis. 1979); *Reproductive Health Services v. Freeman*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,160 (8th Cir. Jan. 9, 1980).

* In oral argument to this Court, the attorney for the state in *Maher* recognized the crucial distinction between the claims advanced there and here:

> We believe that the fallacy of the District Court's reasoning in this case was that Connecticut has no program for funding the medical expenses of pregnancy as such or prenatal or postnatal care. What it does have is

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The *Maher* discussion of *Shapiro* makes this clear in its summation: "We find no support in the right-to-travel cases for the view that Connecticut must show a compelling interest for its decision not to fund *elective* abortions." 432 U.S. at 475n.8 (emphasis added).

Application of the compelling state interest test requires, of course, that the state disfavor or "penalize" exercise of a fundamental right in more than a *de minimis* way. *See Bellotti v. Baird*, 428 U.S. 132, 147, 149-50 (1976). *Maher* found no "penalty" because there was no affirmative state duty to finance abortions and hence no discrimination in the absence of a state program providing elective care generally. *Maher* takes no issue with what *Shapiro* established: discriminatory denial of public assistance funds can act to penalize exercise of a fundamental right.

The most substantial guidance on the nature of "penalties" appears in opinions in *Memorial Hospital v. Maricopa County*, 415 U.S. 250 (1974). In *Maricopa County*, Arizona provided emergency medical care to those not satisfying a durational residence requirement, much as Illinois will here provide an abortion if a pregnant woman is in imminent danger of dying without one. But Arizona would not provide medically necessary

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> a program to pay for medical expenses which are medically necessary for the patient's health.
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> * * *
>
> We think there would be validity to the District Court's opinion . . . if abortions which were admittedly medically necessary for the patient's health were excluded from Connecticut's program, which they are not.

95 Kurland & Casper, LANDMARK BRIEFS AND ARGUMENTS OF THE SUPREME COURT OF THE UNITED STATES: CONSTITUTIONAL LAW 358-59 (1976 Term Supp.).

care except in emergencies to those failing to satisfy a one year residence requirement. Relying on *Shapiro*, *Maricopa County* found an unconstitutional discrimination against those who recently exercised their fundamental right of interstate travel.

The Court's opinion made clear that discriminatory denial of medical care was as much a "penalty" as the similar denial of cash assistance in *Shapiro*:

> Whatever the ultimate parameters of the *Shapiro* penalty analysis, it is at least clear that medical care is as much "a basic necessity of life" to an indigent as welfare assistance. And, governmental privileges or benefits necessary to basic sustenance have often been viewed as being of greater constitutional significance than less essential forms of governmental entitlements. 415 U.S. at 259.*

Justice Rehnquist dissented, largely on the question of what constituted a "penalty" on exercise of a fundamental right:

> It seems to me that the line to be derived from our prior cases is that some financial impositions on interstate travelers have such indirect or inconsequential impact on travel that they simply do not constitute the type of direct purposeful barrier struck down in . . . *Shapiro*.
>
> * * *
>
> [T]he Court should examine . . . whether the challenged requirement erects a real and purposeful barrier to movement, or the threat of such a

* *Maher* suggested that criminal sanctions would be penalties (432 U.S. at 474n.8), but *Maricopa County*, *Shapiro*, *Maher*, and other decisions make clear that criminal sanctions are not the only burdens triggering strict scrutiny of state infringement of fundamental rights. *See, e.g., Moore v. City of East Cleveland*, 431 U.S. 494 (1977); *Bullock v. Carter*, 405 U.S. 134 (1972).

> barrier, or whether the effects on travel, viewed realistically, are merely incidental and remote. 415 U.S. at 284-85.

Justice Rehnquist described this "real and purposeful" standard as "supported by this Court's decisions . . . [and] eminently sensible and workable." *Id.*

Whichever of these two views of "penalties" is accepted, what Illinois has done penalizes a woman's fundamental right in the abortion decision. The Illinois legislature's *precise* purpose was to prevent as many women as possible from exercising this right (*see* pp. 50-53 *infra*). The evidence of this purpose is far more substantial than was the evidence in *Shapiro* of a purpose to inhibit travel. And the barrier Illinois imposes is highly effective (*see* p. 18 *supra*). The women affected are living on an income that Illinois itself defines as subsistence—without any allowance for medical needs. As Justice Stevens said in denying a stay of the injunction, "meaningful exercise of this constitutional right depends on the actual availability of abortions. . . . [I]f the judgment is stayed, the constitutional right to choose will be for many meaningless."* *Williams v. Zbaraz*, 99

* Defendant Miller's predecessor agreed (*see* p. 18 *supra*). Teen-agers, who will disproportionately require medically necessary abortions (A.35), can be expected to have even less access to funds than older indigent women. For teen-aged Medicaid recipients confined in state mental institutions, *see* 42 U.S.C. § 1396d(a)(16) (1976), alternative access to care would be completely foreclosed. And even if a pregnant woman somehow obtains the money for a private abortion, she will have done so only at the cost of delay. But the "increased danger . . . [from abortion] is measurable from each week to the next" (A.30). Since the state is well aware of all these facts, its refusal to fund medically needed abortions for those it knows to be dependent upon it for medical care amounts to "unnecessary and wanton infliction of pain," *Estelle v. Gamble*, 429 U.S. 97, 104 (1976), *quoting Gregg v. Georgia*, 428 U.S. 153 (1976); which is "inconsistent with contemporary standards of decency." *Estelle v. Gamble*, 429 U.S. at 103.

S.Ct. 2095, 2099 (1979); *see Singleton v. Wulff*, 428 U.S. 106, 117 (1976); *Maher v. Roe*, 432 U.S. 464, 474 (1977); *see generally McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 at 9977-78 (slip op. at 57-60) (E.D.N.Y. Jan. 15, 1980). In *Shapiro*, in contrast, there was no determination that denial of welfare actually deterred interstate travel. 394 U.S. at 650 (Warren, C.J. dissenting). *See Dunn v. Blumstein*, 405 U.S. 330, 338-39 (1972). Similarly, in *Maricopa County*, "there [was] no evidence . . . that anyone was actually deterred from traveling by the challenged restriction." 415 U.S. at 257.

Appellants' rebuttal of this penalty analysis is mostly a rote invocation of *Maher*, with no recognition that refusal to fund elective abortions is a neutral stance for a state with a medical assistance program not covering elective procedures generally, while refusal to fund medically necessary abortions is not (*see* pp. 44-46 *supra*). Intervenors add a misfocused reliance on *Meyer v. Nebraska*, 262 U.S. 390 (1923), and *Pierce v. Society of Sisters*, 268 U.S. 510 (1925), where this Court struck down state laws forbidding, respectively, teaching in a foreign language and sending a child to a private school (Int. Br. 41-42, 66-67). *Maher* relied on these two decisions to support its distinction between "State *attempts* to impose its will" and state "power to encourage actions." 434 U.S. at 476 (emphasis added). But Illinois *is* here attempting to impose its will. Despite rationalizations to the contrary, it is not trying to encourage anything (*see* pp. 50-53 *infra*). As a result *Meyer* and *Pierce* are irrelevant—except as they suggest the poverty of appellants' positions. If Illinois had a scholarship program for study of any foreign language, but made German ineligible, or subsidized chemistry training at all private schools, except Catholic ones, the

actions would be analogous to what the state has done here. And those actions would also clearly constitute unconstitutional penalties. The rights involved here, of course, "are of a far greater degree of significance and personal intimacy than" the rights involved in *Pierce* and *Meyer*. *Roe v. Wade*, 410 U.S. 113, 170 (1973) (Stewart, J. concurring).* Thus strict scrutiny must be applied to review Illinois' discrimination against women requiring medically necessary abortions.

B. Illinois' Discrimination Against Indigent Women Requiring Medically Necessary Abortions Is Not Rationally Related To Any Legitimate State Interest, Let Alone Justified By Any Compelling One.

Despite the penalty imposed by Illinois, the state discrimination could still be sustained if shown to support a "compelling state interest." But Illinois' discrimination serves no state interest approaching that level of importance. Indeed, Illinois adopted its devastating restriction of medical assistance funding for medically necessary abortions in pursuit of no legitimate state interest at all. And its action is not a rational way to serve even the legitimate interests that are now advanced as after-the-fact rationalizations for it.

All appellants urge, with somewhat varying language, a legitimate state interest in protection of potential life (U.S. Br. 55; Int. Br. 19; St. Br. 62). This is undeniably a legitimate state interest (albeit never one outweighing the woman's health interest, *see* pp. 53-56 *infra*), but Illinois' actual interest was not in protecting potential life. Illinois passed its restrictive abortion funding

* The analogy would thus be even closer if Illinois provided transportation to the polls for any voter except those wishing to vote for a particular candidate. *Cf. Buckley v. Valeo*, 424 U.S. 1, 293 (1976) (Rehnquist, J. dissenting); *see also Southeastern Promotions, Ltd. v. Conrad*, 420 U.S. 546 (1975).

statute to protect what it perceived, not as potential life, but as actual fully developed human life, a misconception which alone explains the irrationality and cruelty of the Illinois statute.

P.A. 80-1091 contains no statement of purpose, but the Illinois legislature has made clear the attitude motivating all Illinois abortion legislation. In 1975, the legislature passed sweeping abortion legislation declaring:

> [T]he General Assembly of the State of Illinois . . . [reaffirms] the long-standing policy of this State, that the unborn child is a human being from the time of conception and is, therefore, a legal person for purposes of the unborn child's right to life and is entitled to the right to life from conception . . . . ILL. REV. STAT. ch.38, § 81-21 (1975).

See also P.A. 81-1078, § 1, ILL. REV. STAT. ch.38, § 81-21 (Supp. 1979). The State acknowledges this as "the policy of the State of Illinois respecting the value it assigns to fetal life" (St. Br. 33).

The legislative history of P.A. 80-1091 similarly reveals equation of a fetus with a human being as the single-minded preoccupation of its proponents. The overwhelming emphasis in the legislative debates was that abortion was equivalent to homicide and thus to be prevented at virtually any cost. As Senator Rhoads characterized the issue:

> Either one accepts the premise that the unborn is a human life and therefore the termination of the child is an act of homicide, or one does not accept that premise. I do, and therefore can't vote any other way but yes on the bill (A.59; *see* A.84).

See also remarks of Rep. Leinenweber (A.48, 68); Sen. Rock (A.85); Sen. Lemke (A.64, 88); Rep. Johnson (A.50);

Rep. Pullen (A.52); Rep. Kelly (A.68); Rep. Willer (A.80); Rep. Deuster (A.81, quoted at St. Br. 36); Sen. Knuppel (A.86).

Prevented by *Roe v. Wade* from forbidding abortion outright, the proponents of P.A. 80-1091 adopted the half-way measure they thought available to them—forbidding it to the poor. A remark by Representative Bradley captures the essence of the legislative intent behind P.A. 80-1091. "It's a relatively simple bill . . . . It does not prohibit anybody from having an abortion. It prohibits the people who are on welfare from having an abortion" (A.78).

Only when Illinois' action is seen as an effort to protect what the legislature misperceived as actual, not potential, human life does its action become understandable. If a legislature identifies its choice as being between the health of one human being and the life of another, it is at least plausible for it affirmatively to choose the latter. But if a legislature legitimately can equate a fetus with a human being, it would be permissible to prohibit abortion outright, as a simple complement to homicide laws. Since *Roe v. Wade* and numerous subsequent decisions put such action beyond a state's power, they must be understood as holding illegitimate what actually motivated Illinois here. A legislature may not, "by adopting one theory of life, . . . override the rights of the pregnant woman that are at stake." *Roe v. Wade*, 410 U.S. 113, 162 (1973).

Illinois has acknowledged the clash between its motivation and the essential holding of *Roe* and later abortion decisions. The 1975 legislation declares that the "long-standing policy of this State to protect the right to life of the unborn child from conception by prohibiting abortion unless necessary to preserve the life of the

mother is impermissible only because of the decisions of the United States Supreme Court. . . ." *See* St. Br. 33; P.A. 81-1078, § 1, ILL. REV. STAT. ch.38, ¶81-21 (Supp. 1979)).

With the actual motivation for Illinois' discrimination both clear and clearly illegitimate, there is no need to go further and test the state action for its service of fictitious state purposes.* *See Califano v. Goldfarb*, 430 U.S. 199, 212-13 (1977); *Weinberger v. Wiesenfeld*, 420 U.S. 636, 648 (1975); *Trimble v. Gordon*, 430 U.S. 762 (1977); *Califano v. Webster*, 430 U.S. 313, 317 (1977) (*per curiam*); *Eisenstadt v. Baird*, 405 U.S. 438, 448, 450 (1972); *Reitman v. Mulkey*, 387 U.S. 369, 381 (1967); *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 79 (1976); *United States Department of Agriculture v. Moreno*, 413 U.S. 528 (1973); *Village of Arlington Heights v. Metropolitan Housing Development Corp.*, 429 U.S. 252, 264-68 (1977); *Zablocki v. Redhail*, 434 U.S. 374, 391 (1978) (Burger, C.J. concurring).

If an interest in protecting potential life is nonetheless thought to be available to Illinois as a hypothetical justification, that interest is not compelling, nor is the legislation rationally related to such an interest. That potential life is not a compelling interest in the periods before viability of the fetus—the periods involved here—is an essential part of the holding in *Roe v. Wade*, 410 U.S. 113 (1973). It was reiterated only last Term in

* At one point, the intervenors appear to concede both that only "actual" goals can justify legislative action and that a state goal to "'chill' the exercise of a decision whether or not to abort" is illegitimate (Int. Br. 69). Having effectively conceded the case, they then attempt to resurrect it by simply asserting, without support, that the state had additional "positive purposes" (*id*). Similarly Illinois appears to concede that it had no actual purpose beyond what it refers to as protection of "fetal life" (*see* St. Br. 33, 34).

Colautti v. Franklin, 439 U.S. 379, 386 (1979). Even if an interest in potential life were a compelling one for the state—as this Court has held it is after viability of the fetus, *Roe v. Wade*, 410 U.S. at 163 (1973)—it still would not justify the endangerment of a woman's health, let alone her life, that is the direct and intended result of what Illinois has undertaken here. *Roe v. Wade*, 410 U.S. at 164, 165 (1973); *Colautti v. Franklin*, 439 U.S. 379, 387 (1979).* "[T]he State's interest in potential life is never so great that it can outweigh the woman's interest in her health . . . ." *Williams v. Zbaraz*, 99 S.Ct. 2095, 2098 (Stevens, J. denying stay).

This same conclusion follows even if the standard of review is the more permissive rational basis test. Indeed, because protection of potential life was not Illinois' actual goal, it is hardly surprising that the legislature

* The fact that Illinois' precise purpose is to " 'chill' the exercise" (Int. Br. 69) of a fundamental right, and that its action accomplishes its goal, leads to the conclusion that Illinois is depriving indigent pregnant women of due process as well as equal protection of the laws. Even when a state does not prohibit a protected activity, if its action is "tantamount to a prohibition," it is "inconsistent with the essential holding of *Roe v. Wade* and . . . cannot stand." *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 102 (1976) (Stevens, J. concurring in part and dissenting in part); *see San Antonio Independent School Dist. v. Rodriguez*, 411 U.S. 1, 25n.60 (1973); *Griswold v. Connecticut*, 381 U.S. 479, 503 (1965) (White, J. concurring); *cf. Geduldig v. Aiello*, 417 U.S. 484, 496 & n.20 (1974). The far less restrictive action in *Maher* may have been similarly motivated (*see* Perry, *The Abortion Funding Cases: A Comment On the Supreme Court's Role in American Government*, 66 GEO. L.J. 1191 (1978)), but no evidence of such a purpose approaching the persuasiveness of the present record was even hinted at in the opinion. In addition the price the woman must pay because of the action here—her health and perhaps her life—is very different from the inconvenience or displeasure experienced in *Maher*. *See Sherbert v. Verner*, 374 U.S. 398 (1963).

chose an irrational means to that fictitious end. Only with this insight is it even comprehensible that Illinois is sacrificing a woman's interest in her privacy, substantial state funds (and hence public welfare needs of these and other recipients) and, most devastatingly, a woman's health and possibly her life to a purported interest in potential life.

Viewed as a means to protect potential life, Illinois' action is harsh and reckless in the extreme, as this Court's decisions essentially have held already. Since *Roe v. Wade*, this Court has repeatedly struck down state attempts to interfere with the woman's rights in the abortion decision, frequently when her health was involved. Indeed, on the basis of the rationality requirement alone, it has held unconstitutional at least three state restrictions interfering with a woman's health. *Doe v. Bolton*, 410 U.S. 179, 194, 199 (1973) (hospital accreditation and two doctor concurrence); *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 79 (1976) (saline amniocentesis). And only last Term this Court reiterated the paramount importance of the woman's health in the balance of interests; even after viability, state regulation or prohibition of abortion is permissible "except where necessary, in appropriate medical judgment, to preserve the life or health of the pregnant woman." *Colautti v. Franklin*, 439 U.S. 379, 387 (1979); *see Williams v. Zbaraz*, 99 S.Ct. 2095, 2098 (1979) (Stevens, J. denying stay).

Appellants can point to no abortion decision of this Court that allows a pregnant woman's health to be subordinated in any but the most insignificant ways to a legitimate state interest—or even a compelling one. And that includes *Maher v. Roe*, 432 U.S. 464 (1977), where no medical concerns were involved at all. In a program

designed to provide medically necessary care to recipients, Illinois' denial of such care to the women here, damaging their health, is irrational. *See also Reed v. Reed*, 404 U.S. 71, 76 (1971); *Royster Guano Co. v. Virginia*, 253 U.S. 412, 415 (1920).

The lack of any rational relationship to a state interest in potential life is further highlighted by *Maher*. Illinois writes of encouraging "childbirth," St. Br. 78 (*see* U.S. Br. 55; Int. Br. 19), *citing Maher v. Roe*, 432 U.S. 464 (1977). But the state presumably has no interest in the process of birth itself, save in protecting the woman's health during it (*see* p. 39 *supra*). Accordingly, any interest in "childbirth" is but a semantic variation of the other asserted interests in potential life and demographic control.* *See Women's Health Services, Inc. v. Maher*, Civ. No. H-79-405, slip op. at 22-23 (D. Conn. Jan. 7, 1980). But in explaining the nature of the state interest in *Maher*, this Court referred to "normal childbirth," 432 U.S. at 478, 479 (*citing Beal v. Doe*, 432 U.S. 438, 446 (1977)). This emphasis on normalcy necessarily

* Illinois was not actually motivated by any concern for the future demography of the state, as claimed by the intervenors (Int. Br. 19; *cf.* St. Br. 80; *but see id.* at 62). The only support for such a concern is the possibly facetious remark of one Illinois legislator about future support for his pension (*see* Int. Br. 49). Illinois in fact spends large sums of money each year for family planning services: "Services and supplies for the purpose of family planning are covered regardless of age, sex, or marital status . . . . Contraceptive supplies may be dispensed or prescribed or ordered." (St. App. 40a: § A-226; *see* St. Br. 47; *Reproductive Health Services v. Freeman*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,160 at 10,090-91n.20 (8th Cir. Jan. 9, 1980). Illinois even covers *nontherapeutic* sterilization under its medical assistance programs (St. App. 17a: § A-205.2).

qualifies any interest in potential life or demographics of a state acting rationally.

If the state has an interest in "normal" childbirth, it has none in abnormal childbirth and the cruelty resulting from the restrictions Illinois has imposed. There will undoubtedly be additional deaths and complications from abnormal childbirths and from illegal abortions (*see* pp. 8-20 *supra*). Statistical conclusions about "morbidity and mortality" and antiseptically professional terms in which doctors describe the results of refusing medically necessary abortions cannot realistically portray the consequences for pregnant women and girls coerced into furthering the state's alleged preference for "childbirth," "potential life" or "demographics." Medical terminology used to define the results of prolonging abnormal pregnancies refers, in more common parlance, to: juvenile diabetics who become blind; victims of sickle cell crisis (involving unusually painful and widespread blood clots, carrying a risk of kidney failure and heart failure); women with cancer who are forced to choose between continuing chemotherapy treatment (thereby risking massive injury to the fetus) and stopping chemotherapy treatment (thereby risking rapid spread of the cancer); women with uterine tumors attended by severe bleeding into the tumor, partial paralysis, rapidly falling blood pressure and shock; women who suffer from the ordinary "diseases" of poverty—hypertension and malnutrition—developing preeclampsia, potentially resulting in vascular disease, pulmonary edema, kidney and brain damage and stroke. *See generally* A.32-36, 108, 110-11, 117, 125-28; *McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 at 9990-92, 9995 (slip op. at 104-10, 119-20) (E.D.N.Y. Jan. 15, 1980). These are forms of "torture or lingering death" that would be

unconstitutional if the state imposed them on convicted felons. *See Gregg v. Georgia*, 428 U.S. 153, 169-71 (1976); *Estelle v. Gamble*, 429 U.S. 97, 101-04 (1976). To impose them on a teenaged girl for the "crimes" of not knowing what contraception is and being raised in indigency, or on an adult for contraceptive failure, perverts the concept of "normal childbirth."

There is nothing "normal" about the coerced childbirths at issue here. This Court has never held childbirth endangering the life or health of a woman to be "normal." *Cf. Geduldig v. Aiello*, 417 U.S. 484 (1974) (repeatedly relying upon the distinction between "normal pregnancy and childbirth" and that involving "medical complications"). "Childbirth is 'abnormal,' . . . when it poses, relative to abortion, a significant threat to the health or life of the mother." *Reproductive Health Services v. Freeman*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,160 at 10,086 (8th Cir. Jan. 9, 1980); *see Women's Health Services, Inc. v. Maher*, Civ. No. H-79-405, slip op. at 23 (D. Conn. Jan. 7, 1980).

Appellants advance several other interests they claim are served by Illinois' discrimination. Again, none of these actually motivated the state; none of them is a compelling state interest; a number of them are illegitimate, and none is even rationally served by withdrawing funding for medically necessary abortions.

The United States writes of a "desire to avoid spending tax revenues to support an activity that many taxpayers find morally repugnant" (U.S. Br. 55). The other appellants express the same thought in different words (*see* Int. Br. 19; St. Br. 77). This is an expression, however, not of a state interest, but of constitutional conclusion.

Any allocative decision could be asserted to reflect taxpayers' moral judgments and any governmental action to represent voters' moral values. But the decisions of this Court do not permit irrational or illegitimate governmental action to be so insulated from constitutional scrutiny. The values that inhere in the Constitution cannot be trivialized in this way. *Roe v. Wade*, 410 U.S. 113 (1973); *Loving v. Virginia*, 388 U.S. 1 (1967); *Epperson v. Arkansas*, 393 U.S. 97 (1968); *United States Department of Agriculture v. Moreno*, 413 U.S. 528 (1973); *Westcott v. Califano*, 99 S.Ct. 2655 (1979); *Carey v. Population Services International*, 431 U.S. 678 (1977); *Califano v. Goldfarb*, 430 U.S. 199, 207 (1977).*

Neither Illinois nor the United States relies on any fiscal purpose for the discrimination against women requiring medically necessary abortions (*see* St. Br. 69, 77, 80). The intervenors persist in their incorrect claim that Illinois has such an interest. Illinois' refusal to fund medically necessary abortions actually costs the state a great deal of money, thus diminishing the benefits available for all groups of recipients. The Illinois legislative debates reflect an awareness of this (*see* A.64)

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* Constitutional rights will belong only to those not dependent on spending programs, if moral judgments beyond the government's power to impose by other means, can be governmentally imposed through spending programs, simply by invoking the name of the taxpayers. The difference between taxpayers as individuals and taxpayers speaking through government is absolutely fundamental to our constitutional system. "[W]hen the choice is made by the government, the obligation to afford all persons equal protection of the law arises." *Eskra v. Morton*, 524 F.2d 9, 14 (7th Cir. 1975).

and contain no hint of the illusion that the state might save money.*

For this reason, appellants' reliance upon *Dandridge v. Williams*, 397 U.S. 471 (1970), is perverse. This Court does accord substantial deference to state allocative decisions in social welfare programs in the absence of strong countervailing considerations such as the health of pregnant women or their fundamental privacy rights that are in jeopardy here. But welfare classifications are usually employed for the purpose of allocating limited funds among various groups of recipients. In such cases this Court cannot forbid the disfavoring of one group

* *See Maher v. Roe*, 432 U.S. 464, 478-79 (1977); *Williams v. Zbaraz*, 99 S.Ct. 2095, 2098 (1979); *Zbaraz v. Quern*, 469 F.Supp. 1212 (1979) (U.S.J.S. App. 14a); *Hodgson v. Board of County Comm'rs*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,159 at 10,079n.16 (8th Cir. Jan. 9, 1980); *Reproductive Health Services v. Freeman*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,160 at 10,090n.20 (8th Cir. Jan. 9, 1980); *Women's Health Services, Inc. v. Maher*, Civ. No. H-79-405, slip op. at 23-24 & n.16 (D.Conn. Jan. 7, 1980); *McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 at 9970 (slip op. at 31) (E.D.N.Y. Jan. 15, 1980). Intervenors support their argument solely by reference to an article which Judge Blumenfeld recently characterized as "a secondary source that in turn relies largely on foreign studies and questionable conjecture [and] is thus unconvincing . . . ." *Women's Health Services, Inc. v. Maher*, Civ. No. H-79-405, slip op. at 24 (D.Conn. Jan. 7, 1980). Both the district court and the court of appeals understandably paid the argument no heed when it was presented, along with appellees' more detailed rebuttal (R.111: pp.6-9).

In 1978, as the district court found, the average cost to the state of an abortion was less than $150. In contrast, a childbirth cost more than $1350 (U.S.J.S. App. 14a, n.8). When indeterminate public support costs for a child are added to the latter figure, the cost saving to the state from each medically necessary abortion is substantial. Using the conservative figure of $2000 in savings per medically necessary abortion and assuming approximately 10,000 such medically necessary abortions per year (*see* p. 7 *supra*), the savings in Illinois could amount to $20,000,000 per year.

without placing the benefits of another group in jeopardy. The Court expressed this concern in *Dandridge* by saying:

> [T]he Constitution does not empower this Court to second-guess state officials charged with the difficult responsibility of allocating *limited* public welfare funds among the myriad of potential recipients. 397 U.S. at 487 (emphasis added).

Since the refusal to fund medically necessary abortions reduces rather than expands the funds available generally for medical assistance, however, it exacerbates the very allocative dilemma that led the Court to its stance of deference in *Dandridge*. Assuming that public assistance funds are limited, the state's action sacrifices not only maternal life, health, and privacy, but the lives and health of other beneficiaries of the public assistance program as well. This Court's decisions have never countenanced such action, under the rationality standard or any other.

The intervenors suggest that the state was pursuing an interest in "protect[ing] itself from abuse and fraud" (Int. Br. 63). Illinois has an interest in preventing fraud by medical practitioners taking part in its medical assistance programs. But concern with Medicaid fraud is not limited to the provision of abortion; doctors have an economic interest in providing any reimbursable service (*see* Int. Br. 82-83). Both federal and state law provide adequate safeguards against fraud (*see* App. A, pp. 2a-3a *infra*).* There is no indication that the state

* *See also* The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, Pub.L.No. 95-142, 91 Stat. 1175 (codified in scattered sections of 42 U.S.C.), strengthening a variety of anti-fraud and abuse provisions generally, and confirming that a state cannot intrude on physicians' decisions as to medical necessity (*see* pp. 81-85 *infra*).

needed or was pursuing any special concern with fraud in performing abortions. *See Reproductive Health Services v. Freeman*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,160 at 10,080 (8th Cir. Jan. 9, 1980).

The intervenors correctly cite *Shapiro v. Thompson*, 394 U.S. 618, 637 (1969), for the legitimacy of a state purpose of fraud prevention (Int. Br. 63). What they fail to mention is *Shapiro*'s rejection of fraud prevention as a justification because it was "unreasonable to accomplish this objective by [a] blunderbuss method . . . ." *Shapiro v. Thompson*, 394 U.S. at 637; *see, e.g., United States Department of Agriculture v. Murry*, 413 U.S. 508, 512-14 (1973). It is similarly hard to imagine a more blunderbuss method of preventing a doctor from falsely claiming that an abortion is medically necessary than foreclosing him from performing any medically necessary abortions other than those rare ones necessary to preserve a woman's life. Combined with the overwhelming direct evidence that Illinois' purpose was to stop abortions (*see* pp. 50-53 *supra*), the conclusion is inescapable that the state was not in fact trying to prevent fraud.

At points the intervenors and the State suggest that Illinois was seeking to prevent not fraud but medically misguided decisions. The intervenors say that some doctors simply "*prefer* to abort." Int. Br. 75 (emphasis in original); *see also* St. Br. 44, 55. Both the intervenors and the State unhesitatingly assert now for the first time that abortions are never medically necessary except in life-preserving situations, because, they claim, alternative forms of treatment are available (Int. Br. 72-

75; St. Br. 40-43; *see also* Amicus Brief of Certain Physicians . . ., *passim*).*

* Quite apart from the inappropriateness of presenting these arguments from "medical literature" (Int. Br. 75) at this point where they cannot be rebutted or subjected to cross-examination in the appropriate fashion, the attempts exhibit both internal inconsistency and a stark lack of touch with reality. Thus the intervenors assert without evidentiary support that there is "mounting evidence that abortion complications—both currently reported and projected—may lead to Medicaid costs greatly in excess of those associated with pregnancy complications" (Int. Br. 58). At other points, however, they rely upon a report of the Center for Disease Control (A.138-42) that showed "[n]o increase in abortion-related complications" in states withholding medical assistance funding for abortions but also showed "no significant difference between institutions in funded and non-funded states in the proportion of Medicaid women with abortion complications . . ." (Int. Br. 12). Intervenors' principal use of this same report (Int. Br. 12, 75) is to quarrel with the district court's finding that Illinois' action will result in a substantial increase in maternal morbidity and mortality. Despite their motion for summary judgment urging "no dispute over facts essential to the outcome of this litigation" (A.101), intervenors rely on the report as "conflicting evidence" that should have led to an "evidentiary hearing" below (Int. Br. 12). The statistics for which the intervenors cite the report, however, deal with a subject irrelevant to the district court's finding, which concerned the effect on women who do not obtain abortions, rather than on those who do. The report provides strong confirmation of the district court's finding: "3 deaths of Medicaid-eligible women [over an eight month period] . . . in states [with restrictions similar to Illinois']: 1 . . . directly related to the absence of public funds; the other 2 . . . indirectly related" (A.138). In addition, it shows that funding restrictions lead to "later gestational age at the time of abortion" which in turn leads to substantial increase in the risks from abortion (*see* A.139, 141-42); *see generally McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶ 30,155 at 9979-81 (slip op. at 61-67) (E.D.N.Y. Jan. 15, 1980).

Illinois presents an unsupported medical argument that " 'deep vein' thrombophlebitis" can always be treated late in pregnancy "when it in fact strikes" (St. Br. 41), without even mentioning the evidence in the record that the danger from abortion itself increases rapidly as pregnancy progresses (*see*

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The intervenors and the State repeatedly suggest the non-medical necessity of abortions, except those necessary to preserve the life of the mother (*see* Int. Br. 26-27, 52n.9, 71; St. Br. 68, 76, 78, 82), but the record below has no evidence to support the claim, and an overwhelming body of evidence to the contrary. *See*

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A.30, 141-42). Intervenors' medical arguments urge "bedrest," 'hospitalization," "a change in lifestyle," "[p]roper attention to . . . physical activity, and stress" as at least partial alternatives to abortion for certain conditions (Int. Br. 73-74). But "[t]heoretical alternatives to abortion are not considerations if they are not actually available to the patient. A pregnant woman with varicose veins, for instance, can substantially lower any risk she faces with complete bedrest. This is not an alternative for a woman, such as plaintiff Jane Doe, with small children" (A.130; *see also* A.36, 107-08).

It is not possible to deal here with all the medical assertions presented now by appellants and their amici for the first time, with no basis in the record. Suffice it to say that most of the authorities cited do not stand for the proposition that abortions in other than life-preserving situations are not medically necessary. Most deal with problems of pregnancy on the assumption that the woman and her doctor have already made the decision to carry the pregnancy to term. *See, e.g.*, ROMNEY, GYNECOLOGY AND OBSTETRICS—THE HEALTH CARE OF WOMEN (1975); WILLIAMS, OBSTETRICS (1976) (cited in St. Br. 39-41); Morrison & Wiser, *The Use of Prophylactic Partial Exchange Transfusion in Pregnancies Associated With Sickle Cell Hemoglobinopathies*, 48 OBSTETRICS AND GYNECOLOGY 516 (1976); Gant *et al.*, *Clinical Management of Pregnancy-Induced Hypertension*, 21 CLINICAL OBSTETRICS AND GYNECOLOGY 397 (1978) (cited in Int. Br. 72-73); Blattner *et al.*, *Pregnancy Outcome in Women With Sickle Cell Trait*, 238 J.A.M.A. 1342 (1977); Gallus *et al.*, *Prevention of Venous Thrombosis With Small Subcutaneous Doses of Heparin*, 235 J.A.M.A. 1980 (1976) (cited in Amicus Brief of Certain Physicians . . . , 5, 12). Some of the authorities in fact recognize the medical advisability of abortion under non-life threatening circumstances. *See* Ueland, *Cardiovascular Diseases Complicating Pregnancy*, 21 CLINICAL OBSTETRICS AND GYNECOLOGY 429, 433 (1978); Levine & Colea, *When Pregnancy Complicates Chronic Granulocytic Leukemia*, 13 CONTEMPORARY OB/GYN 49 (1979) (cited in Amicus Brief of Certain Physicians . . . , 7, 12).

A.28-37, 38, 40, 89-90, 102-12, 113-21, 123-32, 138-42; *see also Roe v. Wade*, 410 U.S. 113, 121, 127, 139, 142, 153, 164, 165 (1973); *Doe v. Bolton*, 410 U.S. 179, 192 (1973); *Beal v. Doe*, 432 U.S. 438, 441-42n.3, 444, 445n.9 (1977). Judge Dooling faced a similar claim of the non-necessity of abortion in *McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 at 10,045 (slip op. at 308) (E.D.N.Y. Jan. 15, 1980). After an extensive evidentiary hearing, he concluded that:

> the abortion procedure is a means of safeguarding the health of the pregnant woman from exposure to serious impairment, and to avert unacceptably high risks of death; . . . the 'life endangerment' . . . standard . . . do[es] not include but exclude[s] the greater part of the cases in which the profession would recommend abortion as medically necessary procedure to safeguard the pregnant woman's health. *Id.*

Similar conclusions have been reached by each court that has addressed the question. *See, e.g., Reproductive Health Services v. Freeman*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,160 at 10,080 (8th Cir. Jan. 9, 1980).* The finding below of a substantial "increase . . . [in] maternal morbidity and mortality among indigent pregnant women" was correct.**

* In 1978 Congress passed the Adolescent Pregnancy Prevention and Care Act, finding *inter alia* that "pregnancy . . . among adolescents . . . often results in severe adverse health . . . consequences . . . ." Pub. L. No. 95-626, § 601(a)(3), 92 Stat. 3551 (codified in 42 U.S.C. § 300a-21).

** It is not at all clear what the United States means when it says that "The parties did not litigate in the courts below the proper application of the relevant statutory language to one or more particular abortions . . ." (U.S. Br. 59n.30). The record is replete with physicians' judgments on the meaning to them of the statutory phrases (*see* A.31, 33-34, 109, 110, 119-20, 124-29). The record shows the severe restrictive effect of both the

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More fundamentally, this Court's abortion decisions have already foreclosed the state from overriding the doctor's ethical and medical responsibilities in abortion decision-making. As indicated earlier, those opinions persistently emphasize the central importance of the woman's health in the configuration of interests involved in the abortion decision. A corollary of this solicitude for the pregnant woman's health has been the paramount role of the doctor, and not the state, in making the medical decisions about how to preserve that health. *See Doe v. Bolton*, 410 U.S. 179 (1973); *Singleton v. Wulff*, 428 U.S. 106 (1976).

This Court has twice confronted state regulation purportedly justified, as here, in medical terms. In *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976), a Missouri statute prohibited the use of saline amniocentesis as an abortion technique after the first twelve weeks of pregnancy. This was no absolute prohibition of abortion, for alternative abortion techniques remained permissible. This Court, however, looked behind purported legislative findings of fact and concluded that Missouri's prohibition of the saline method "as a practical matter . . . forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed." 428 U.S. at 79. For this reason:

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Illinois and Hyde Amendment standards, which are wholly alien to normal medical judgment (*see* pp. 9-12 *supra*). It shows that plaintiff Jane Doe had a medical need for an abortion not fundable under either standard (A.89-92). And the district court's findings are that the "set" of withheld abortions is more than "not empty" (U.S. Br. 59n.30); it "*may* be as *low* as one fifth of the representative cases in which a pregnant woman desires an abortion." U.S.J.S. App. 21a (emphasis added); *see* St. Br. 34n.21.

> [T]he outright legislative proscription of saline fails as a reasonable regulation for the protection of maternal health. It comes into focus, instead, as an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after the first 12 weeks. As such, it does not withstand constitutional challenge. *Id.*

In *Colautti v. Franklin*, 439 U.S. 379 (1979), a Pennsylvania statute required that a doctor use an abortion technique "'which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother. . . .'" 439 U.S. at 389. Despite the explicit reservation of concern for the woman's health, the measure was found unconstitutional in an opinion that repeatedly stressed the necessity for "broad discretion" in the physician. 439 U.S. at 394. Here, of course, Illinois abandons all concern for the woman's health or the normal decision-making process of physicians. The distinction between medically necessary and unnecessary care is firmly grounded in both fact and law. The medical necessity standard is one used in the state's programs generally. That standard permeates the Medicaid statute, which defines the standard by reference to a range of reasonable physician judgment. *See* 42 U.S.C. § 1320c-5(b)(1) (1976) (*reprinted at* p. 7a *infra*).

In the final analysis, appellants' constitutional arguments rest almost exclusively on an attempt, through selective culling of language, to identify the present situation with that presented in *Maher*. Once the simple but central distinction between the two cases is acknowledged, however, *Maher* teaches nothing about the rationality of Illinois' action here as a means to

protect potential life, let alone about state justification satisfying a higher standard of scrutiny. Connecticut's refusal to fund in *Maher* was justifiable in a program not covering elective services generally, as an expression of "a value judgment favoring childbirth over abortion, . . . [implemented] by the allocation of public funds." 432 U.S. at 474. Here there is no expression of a value judgment. There is an affirmative attempt to stop abortions, which if allowed will substantially increase mortality and morbidity in the operation of a health care program. *See* pp. 9-20 *supra*. If what Illinois has done is viewed as expression of a value judgment, however, the expression is accomplished not by a simple allocation of public funds that makes one palatable choice more attractive than another. Rather Illinois has allocated public funds with full understanding that its choice "is not merely unattractive but dangerous . . . ." *Women's Health Services, Inc. v. Maher*, Civ. No. H-79-405, slip op. at 19 (D. Conn. Jan. 7, 1980). "[A]n attempt to persuade by inflicting harm on the listener," however, "is an unacceptable means of conveying a message that is otherwise legitimate." *Carey v. Population Services International*, 431 U.S. 678, 715 (1977) (Stevens, J. concurring); *see* R. Bennett, *"Mere" Rationality In Constitutional Law: Judicial Review and Democratic Theory*, 67 CALIF. L. REV. 1049, 1060-69 (1979).

The United States captures the essence of what is at stake here, by persisting in its claim that "Congress [and presumably Illinois] could rationally choose not to fund any abortions under state Medicaid programs" (U.S. Br. 62). This claim is made in the course of depicting the Illinois program restrictions as a mere "policy choice," as if all values were fungible, and as if *Roe v. Wade* and subsequent abortion decisions of this Court did not exist. If the United States is right and actual maternal life,

health and privacy can be sacrificed to potential life, then the constitutional requirement that a rational means be chosen to serve even legitimate ends has lost all meaning. If the rationality requirement retains any content, however, it places Illinois' reckless disregard of maternal life and health beyond legislative authority. Not a single Justice writing in *Roe v. Wade* came to the defense of the sort of rationality judgment the United States apparently champions here. Writing separately in dissent, Justice Rehnquist said that, "If the Texas statute were to prohibit an abortion even where the mother's life is in jeopardy, I have little doubt that such a statute would lack a rational relation to a valid state objective . . . ." 410 U.S. at 173. And Justice Rehnquist then joined Justice White in intimating that he might have joined the majority if the plaintiff had been claiming a "threat to her mental or physical health." *Doe v. Bolton*, 410 U.S. 179, 221 (1973) (White, J. dissenting).

The uses appellants make of *Maher* and *Poelker* amount essentially to a claim that courts will not review legislative distinctions in social welfare programs, no matter how irrational they are, no matter how unrelated they are to pursuit of legitimate state interests, and no matter what fundamental constitutional rights are thereby disfavored. Both Illinois and the United States, for instance, isolate the following passage from *Maher*: "The Constitution imposes no obligation on the States to pay the pregnancy related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents." 432 U.S. at 469; *see* St. Br. 64; U.S. Br. 51. Their quotations, however, like their arguments, remain incomplete, for these words from *Maher* were immediately followed by their essential equal protection complement: "But when a state decides to alleviate some of the hardships of poverty by providing medical care,

the manner in which it dispenses benefits is subject to constitutional limitations." 432 U.S. at 469-70. *Maher* indeed goes on to quote the rationality standard as formulated in *San Antonio Independent School District v. Rodriguez*, 411 U.S. 1, 17 (1973), itself a case involving public funding: legislation "must . . . be examined to determine whether it rationally furthers some legitimate articulated state purpose and therefore does not constitute an invidious discrimination . . . ."

Illinois recognizes the importance of health to its citizens. For fiscal year 1979 it appropriated 1.6 billion dollars for its medical assistance programs for the poor—more than for all its cash assistance programs meeting needs for food, shelter and clothing. IDPA ANNUAL REPORT 1978, at 18 (1979). In P.A. 80-1091 the state singled out a small and powerless group of the medical assistance recipients as the only one to be denied medically necessary care under its medical assistance programs. Those recipients' distinguishing characteristic is the desire to avail themselves of a medical procedure their doctors have told them is necessary to preserve their health and the choice of which is constitutionally protected. If Illinois is allowed to discriminate in this way, the result will be added sickness and added death. Regardless of the standard under which this state discrimination is to be judged, the Constitution does not allow a program intended to further the health of its indigent citizens to be put to such use.

IV.

THE SOCIAL SECURITY ACT REQUIRES ILLINOIS TO COVER MEDICALLY NECESSARY ABORTION SERVICES FOR ELIGIBLE PREGNANT WOMEN; THIS REQUIREMENT IS UNAFFECTED BY THE HYDE AMENDMENT.

A. Introduction.

While Illinois covers all other medically necessary services in its Medicaid program, it excludes almost all medically necessary abortion services from coverage. In *Beal v. Doe*, 432 U.S. 438 (1977), this Court noted that, although a state is free to refuse to fund medically "*unnecessary*" services, "serious statutory questions might be presented if a state Medicaid plan excluded necessary medical treatment from its coverage . . . ." 432 U.S. at 444-45 (emphasis in the original). The distinction between Pennsylvania's policy in *Beal* and Illinois' policy here is decisive, since the distinction between medically necessary and medically unnecessary services is at the heart of the Medicaid statute and is, in the current context, the only distinction a state may make.

Two groups of persons are eligible for Medicaid. The state is required to extend eligibility to the "categorically needy," a group generally equivalent to recipients of financial assistance (*e.g.*, Aid to Families with Dependent Children, 42 U.S.C. § 601 *et seq.* (1976)). 42 U.S.C. § 1396a(a)(10)(A) (1976); 42 C.F.R. §§ 435.110-.223 (1979). A state can also cover, as Illinois does, the "medically needy" (persons financially ineligible for cash assistance, but whose income is insufficient to meet their medical bills).* 42 U.S.C. § 1396a(a)(10)(C) (1976); 42

* "Medically needy" is thus a Medicaid term of art referring to a certain type of financial eligibility; it does not refer to the need for medically necessary services that all Medicaid recipients share.

C.F.R. §§ 435.300-.325 (1979). Most Medicaid recipients in Illinois are "categorically needy." IDPA, ANNUAL REPORT 1978, at 19 (1979).

Under 42 U.S.C. § 1396a(a)(13)(B) (1976), the state must provide the categorically needy the *mandatory* services specified in 42 U.S.C. § 1396d(a)(1)-(5) (1976, *as amended by* Pub. L. No. 95-210, § 2(a), 91 Stat. 1485 (1977)) including hospital and physicians' services. Coverage of other services listed in § 1396d(a)(6)-(16) (1976) (*e.g.*, dental care, drugs) is optional. The state must provide the medically needy, if covered, with at least the same minimum services listed in 42 U.S.C. § 1396d(a)(1)-(5), or seven of the sixteen categories of services listed in § 1396d(a)(1)-(16). 42 U.S.C. § 1396a(a)(13)(C) (1976). For both groups, Illinois provides all categories of care specified in 42 U.S.C. § 1396d(a) (Medical Assistance Program Rules, St. App. 7a-67a).

A state retains discretion under Medicaid to determine some eligibility groups (*i.e.*, coverage of the medically needy) and some aspects of the package of benefits to which eligible persons are entitled (coverage of optional services, such as dental care or drugs). A state does not have—and Congress has deliberately refused to give to the states—the authority to do what Illinois has done here: exclude medically necessary services by use of a restrictive standard applied to the particular diagnosis or condition of the eligible recipient. It is undisputed that medically necessary abortions would be included in Illinois' coverage of hospital and physicians' services but for P.A. 80-1091. Moreover, the withdrawal of federal funding for almost all medically necessary abortion services under the Hyde Amendment does not alter Illinois' statutory obligation to provide such care.

B. Title XIX Requires Participating States To Cover Medically Necessary Abortion Services.

1. Since the inception of the Medicaid program in 1965, Congress has required that each participating state provide a minimum benefit package for eligible recipients. 42 U.S.C. § 1396a(a)(13)(B) requires, for the categorically needy, "inclusion of at least the care and services" specified in 42 U.S.C. § 1396d(a)(1)-(5); these include inpatient and outpatient hospital services, laboratory and x-ray services, physicians' services, and, as discussed in more detail, *infra*, particular services for children.

Congress considered the inclusion of such a minimum benefit package covering "the most essential" items to be an important advance in meeting the health needs of the poor:

> *Scope of medical assistance.* Under existing laws the State must provide "some institutional and non-institutional care" under the medical assistance for the aged program [the "Kerr-Mills" program.*] There are no minimum benefit requirements at all under the other public assistance vendor medical programs.
>
> The bill would require that by July 1, 1967, [the states cover the mandatory services listed in 42 U.S.C. § 1396d(a)(1)-(5)] . . . . Coverage of other items of medical service would be optional with the States.
>
> * * *
>
> In the opinion of your committee, these [required services] are the most essential items of service

* Social Security Amendments of 1960, Pub. L. No. 86-778, Title VI, § 601(b), 74 Stat. 987 (superseded by Title XIX in each state no later than December 31, 1969, Pub. L. No. 89-97, § 121(b), 79 Stat. 286 (1965), repealed by Pub. L. No. 92-603, 86 Stat. 1329 (1972)).

> which should be included as a minimum if the medical assistance program is to be of significant help to the individual. These minimum items of service are to become effective July 1, 1967; until then, the State plan must include—as now provided in Titles I and XVI—for some institutional and some non-institutional services.

H.R. REP. NO. 213, 89th Cong., 1st Sess. 9-10, 70 (1965). *See also* S. REP. NO. 404, 89th Cong., 1st Sess. 9, 80, *reprinted in* [1965] U.S. CODE CONG. & AD. NEWS 1943, 1950-51, 2021.*

As discussed at pp. 80-85 *infra*, Congress later limited care under Medicaid to that which is medically necessary; with that exception, nothing in the language of 42 U.S.C. § 1396a(a)(13)(B) or any other provision of the Act suggests that a state may impose limitations on these mandatory services. Section 1396a(a)(13)(B) requires the "*inclusion of at least*" these services (emphasis added), not "some" of them, nor indeed "all or part" of them.

Appellants (St. Br. 49, Int. Br. 85) point out that the statute says "the term 'medical assistance' means payment of part or all of the cost of the following care and services . . . ." 42 U.S.C. § 1396d(a) (emphasis added), and rely on the "part or all" language to confer discretion on the states to include only part of the services.

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* Thus, Congress' intent was exactly contrary to that ascribed to it by Massachusetts and other states in their amicus brief; they argue that the Medicaid Act essentially replicated the discretion the Kerr-Mills program permitted as to services. The provision in 42 U.S.C. § 1396a(a)(13)(A) (1976) for "some institutional and some non-institutional care and services" which these amici rely upon as "particularly significant language" (Mass. Br. at 39-40) is shown by the history quoted in the text to be essentially a transitional provision, superseded by the mandate of the five basic services.

The limitation on payment of "cost" rather than provision of "services" is purposeful, and constitutes a term of art defining the eligibility of the medically needy—those persons whose income and resources may exceed cash welfare standards but "are insufficient to meet all of [the] cost" of medical bills. 42 U.S.C. § 1396d(a). They are required to use income in excess of non-medical subsistence needs to pay part of their medical bills; the state pays the remainder. Thus, depending on the state's standard and the individual's income, the state pays "part or all of the cost of" medical care and services.

The history of this language demonstrates that the phrase was tied solely to medically needy eligibility. It originated in the 1960 Kerr-Mills provisions as the device to create a medically needy program for the aged; the pre-Medicaid programs which had no medically needy eligibility had no such language.* But under Kerr-Mills, many states had imposed an objectionable income cut-off point, above which no costs would be paid by the state, and below which all would be. H.R. REP. No. 213, 89th Cong., 1st Sess. 68 (1965). In 1965 the "part or all" language was retained for Medicaid, and Congress added 42 U.S.C. § 1396a(a)(10)(C) to require, in determining eligibility, flexible consideration of medical costs incurred. *Id.* The House Ways and Means Com-

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* Kerr-Mills defined "medical assistance for the aged" as "payment of part or all of the cost of" care and services for aged "persons who are not recipients of [cash benefits]." 42 U.S.C. §§ 306(b), 1385(b) (1970) (repealed 1972). On the other hand, "medical care" for those categories of persons for whom a medically needy program did not exist before 1965 was defined without any such language. 42 U.S.C. § 306 (aged cash recipients); 42 U.S.C. § 606(b) (AFDC recipients); 42 U.S.C. § 1206 (blind recipients); 42 U.S.C. § 1355 (disabled recipients); 42 U.S.C. § 1385 (aged, blind and disabled cash recipients).

mittee explained these provisions, including the language "part or all of the cost" in a section addressing "Determination of need for medical assistance," not in "Scope and definition of medical services," discussed later in its Report. It made clear that the language was meant to define the terms of eligibility for the medically needy:

> Thus *before* [*a medically needy*] *individual is found ineligible for all or part of the cost of his medical needs*, the State must be sure that the income of the individual has been measured in terms of both the State's allowance for basic maintenance needs and the cost of the medical care he requires.

Id. (emphasis added). *See also* S. REP. NO. 404, 89th Cong., 1st Sess. 78-79 (1965), *reprinted in* [1965] U.S. CODE CONG. & AD. NEWS 1943, 2018-19. Thus the "part or all" language in no way dilutes the state's obligation to provide all the services in the mandated categories.

Since 1965 other provisions of the Act have required the States to establish standards to "assure" that the care and services provided "are of high quality," 42 U.S.C. § 1396a(a)(22)(D) (1976), and furnished "in a manner consistent with . . . the best interests of recipients." 42 U.S.C. § 1396a(a)(19) (1976). The states must thus cover treatment which is effective and currently available (*e.g.*, "high quality," *see* p. 94 *infra*).*

The State and the intervenors rely on 42 U.S.C. § 1396a(a)(17) (1976), which has required since 1965 that

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* Congress intended the "best interests" language "to provide some assurance that . . . the States will not administer the provision for services in a way which adversely affects the availability or quality of the care to be provided." S. REP. No. 404, 89th Cong., 1st Sess. 76, *reprinted in* [1965] U.S. CODE CONG. & AD. NEWS 1943, 2017.

the state establish "reasonable standards . . . for determining [eligibility and] the extent of medical assistance under the plan which . . . are consistent with the objectives of [Title XIX]." The legislative history shows that section 1396a(a)(17) does not support what Illinois has done here. Rather, it requires comparable standards for defining eligibility among the groups of persons covered (*i.e.*, the aged, blind, and disabled, and AFDC families). S. REP. NO. 404, 89th Cong., 1st Sess. 77, 79, 81, *reprinted in* [1965] U.S. CODE CONG. & AD. NEWS 2017, 2018, 2019; H.R. REP. NO. 213, 89th Cong., 1st Sess. 67, 69, 71 (1965); *compare Jefferson v. Hackney*, 406 U.S. 535 (1972). Defining who is "categorically needy" and who is "medically needy" necessarily defines the "extent of medical assistance" provided to persons in each group. S. REP NO. 404, *supra*; H.R. REP. NO. 213, *supra*. "The extent of assistance" language also governs the terms under which optional services are to be provided. *See* cases at p. 98n. *infra*. Although we agree with the United States that section 1396a(a)(17) was not intended to affect the state's obligation to provide mandatory services (U.S. Br. at 43-44n.23), if there is any such effect it is one prohibiting Illinois' attempt here to exclude particular medically necessary services from coverage on the basis of diagnosis or treatment. *See* cases cited at p. 98 *infra*.

The preamble to Title XIX has always provided that the purpose of the Medicaid program is to "[enable] each State, as far as practicable under the conditions in such state to furnish (1) medical assistance on behalf of [defined categories of persons] whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396 (1976). Appellants and certain amici assert the preamble vests in the states great discretion as to coverage of medically necessary abortion services. But the enabling language in the

public assistance titles of the Social Security Act has never acted as either a sword for recipients or a shield for the states; it modifies neither minimum eligibility nor minimum assistance provisions.* The Title XIX preamble is only a factor reinforcing state discretion where it otherwise exists, and confirming fiscal practicability as a factor in the exercise of that discretion. *Compare King v. Smith*, 392 U.S. 309 (1968), with *Dandridge v. Williams*, 397 U.S. 471 (1970).

Since its enactment Title XIX has thus required a state to cover all care within the mandatory service categories, and precluded a state from picking and choosing conditions for which it would provide coverage within those categories. Illinois' exclusion of medically necessary abortions is illegal under the Act.

2. Subsequent amendments to Title XIX have retained and reaffirmed the requirement of providing the mandatory services, subject only to an exclusion of medically unnecessary care. Indeed, efforts in 1967 to dilute the mandatory service package for the categorically needy were rejected, since the existing coverage was considered necessary to "make certain that the five basic medical services are provided for the most needy recipients . . . ." S. REP. NO. 744, 90th Cong., 1st Sess. 182, *reprinted in* [1967] U.S. CODE CONG. & AD. NEWS 2834, 3020. Rather, Congress expanded the mandatory service package by adding "early and

* Each Title in the series of public assistance programs opens with the words "for the purpose of . . . enabling each State as far as practicable . . . to furnish . . . assistance. . . ." *See e.g.*, 42 U.S.C. § 601 (AFDC); 42 U.S.C. § 1381 (1970 & Supp. III 1973) (Aid to the Aged, Blind and Disabled).

periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment and other measures to correct or ameliorate defects . . . discovered thereby . . . ." Pub. L. No. 90-248, § 302(a), 81 Stat. 905 (1968) (codified at 42 U.S.C. § 1396d(a)(4)(B). Thus, for women under twenty-one, Illinois is required not only to reimburse all medically necessary mandatory services (including medically necessary abortions), but to *assure* the provision of such services. *See Stanton v. Bond*, 504 F.2d 1246, 1248 (7th Cir. 1974), *cert. denied*, 420 U.S. 984 (1975); *see also* HEW MEDICAL ASSISTANCE MANUAL, Pt. 5, § 5-70-00: "Congress intended to require states to take aggressive steps to screen, diagnose and treat children with health problems."

The original Act included a requirement that states make a "showing" of progress in both "broadening the scope of the care and services . . . and . . . liberalizing the eligibility requirements" in the direction of "comprehensive" coverage of all needy persons and all medical services, including optional ones, by 1977. 42 U.S.C. § 1396b(e) (repealed 1972). This comprehensiveness provision anticipated coverage not only of optional services and groups, but of medically unnecessary services as well (*e.g.*, routine check-ups for adults; cosmetic surgery).* *See* HEW, HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION, SUPP. D, § D-5142; 118

* Read in conjunction with 42 U.S.C. § 1396's "necessary medical services" language, the comprehensiveness provision may have created some tension in the original statute between medically necessary care and a broader mandate of comprehensiveness. As will be seen, Congress later resolved any such tension, but preserved the mandate of providing medically necessary services.

CONG. REC. 33898-99 (1972) (remarks of Sens. Bennett, Long).

Congress temporarily suspended the comprehensiveness provision in 1969. Act of Aug. 9, 1969, Pub. L. No. 91-56, § 2(a), 83 Stat. 99. In initiating the suspension the Senate Finance Committee responded to states' concerns about "the impact of [comprehensiveness] upon State finances" because of the requirement of progressing towards coverage of all of the medically needy and optional services such as "dental care and eye care." S. REP. NO. 222, 91st Cong., 1st Sess. 5-6, *reprinted in* [1969] U.S. CODE CONG. & AD. NEWS 1077, 1081-82. The Committee emphasized that relieving states of the obligation to phase in optional eligibility groups and services was not intended to have any effect on existing mandatory coverage requirements.

> The committee wants to make it clear that this amendment in no way affects the obligation of a State to provide at least the five basic services now required under present law for cash assistance recipients.

Id. at 3, *reprinted in* [1969] U.S. CODE CONG. & AD. NEWS at 1079. Congress coupled the comprehensiveness suspension with a limited maintenance of effort provision, imposing preconditions before a state could cut back on some or all of the optional eligibility and optional services it already had extended in response to the comprehensiveness mandate. Pub. L. No. 91-56, § 2(d).

In 1972 Congress permanently repealed the comprehensiveness provision and eliminated the maintenance of effort requirement. Act of Oct. 30, 1972, Pub. L. No. 92-603, § 230, 86 Stat. 1410 (repealing 42 U.S.C. § 1396b(e)). Again, it acted out of a concern for the fiscal impact of phasing in optional groups and services, and again it left untouched the state's obligation to provide the mandatory services. S. REP. NO. 1230, 92d Cong., 2d Sess. 202 (1972) (repeal relieves states of financial burden of "expansion of . . . program and liberalization of eligibility"). The maintenance of effort provisions were also repealed because they restricted states in responding to short-term fiscal emergencies and because it would have been inconsistent to require states to maintain expenditures which included medically unnecessary services (due to the prior comprehensiveness requirement and lack of a medical necessity standard) when Congress was simultaneously establishing a definitive medical necessity standard in the same law through creation of Professional Standards Review Organizations ("PSROs"). 118 CONG. REC. 33898-99 (1972) (remarks of Sens. Bennett, Long).

A PSRO is an organization of doctors practicing in a geographic area, certified to monitor utilization, appropriateness and quality of hospital and physician services provided under the state Medicaid programs. 42 U.S.C. § 1320c *et seq.* (1976, *as amended by* Pub. L. No. 95-142, 91 Stat. 1175 (1977)). PSROs are to ensure that "provision of health care and . . . payment for such services will be made—(1) only when, and to the extent, *medically necessary*, as determined in the exercise of reasonable limits of professional discretion . . . ." 42 U.S.C. § 1320c (emphasis added).* By July 1, 1974, all states had to recognize the authority of PSROs. 42 U.S.C. § 1320c-13 (1976). Congress intended physicians in PSROs, not state officials, to have the authority to review judgments of medical necessity; the basis was a

* Thus Title XI-B and the 1972 amendments to Title XIX established that states need not cover medically unnecessary services. *See also Beal v. Doe*, 423 U.S. 438 (1977).

firm belief that legislative or administrative intrusions into medical decision-making are disruptive and ill-founded.*

Each PSRO has

> [n]otwithstanding any other provision of law . . . the duty and function . . . to assume, at the earliest date practicable, responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and non-institutional providers . . . for the purpose of determining whether—
>
> (A) such services and items are or were medically necessary; [and]
>
> (B) the quality of such services meets professionally-recognized standards of health care.

42 U.S.C. § 1320c-4(a)(1) (1976, *as amended by* Pub. L. No. 95-142, 91 Stat. 1175 (1977)), *see also* 42 U.S.C.

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* [O]nly physicians are, in general, qualified to judge whether services ordered by other physicians are necessary. The committee is aware of increasing instances of criticism directed at the use of insurance company personnel and Government employees in reviewing the medical necessity of services.

S. REP NO. 1230, 92nd Cong., 2d Sess. 256, 258, 260, 264 (1972); *see also* 118 CONG. REC. 1017, 1019 (1972) (PSROs will determine whether care will be paid under Medicare or Medicaid; government is ill-equipped to perform utilization review) (remarks of Sen. Bennett, PSRO sponsor); *Medicare and Medicaid, Hearings Before Senate Committee on Finance*, Pt. 1, 91st Cong., 2d Sess. 88 (1970) (remarks of John Veneman, Under-Secretary of HEW: "I doubt if we could ever legislate what a doctor should prescribe when he diagnoses the ills of a patient . . . . That has to be a medical judgment"); *see generally* W. Bennett, *Professional Standards Review Organizations-Philosophy and History*, 1975 UTAH L. REV. 355, 356 (PSRO responsibility pre-emptive and "complete"); Gosfield, *Medical Necessity in Medicare and Medicaid: The Implications of Professional Standards Review Organizations*, 51 TEMPLE L. REV. 229 (1978).

§ 1320c-9(a)(1) (1976). The 1972 PSRO statute further requires that the PSROs develop appropriate "norms of care, diagnosis, and treatment" to determine the propriety of medical services. 42 U.S.C. § 1320c-5(a) (1976).

> Such norms with respect to treatment for particular illnesses or health conditions shall include . . . the types and extent of the health care services which, taking into account differing, but acceptable, modes of treatment and methods of organizing and delivering care are considered within the range of appropriate diagnosis and treatment of such illness or health condition, consistent with professionally recognized and accepted patterns of care.

42 U.S.C. § 1320c-5(b) (1976).

While states may maintain some parallel "utilization review,"* particularly during transitional periods before full PSRO assumption of such responsibilities (42 U.S.C. § 1320c-2 (1976)), PSRO norms are to be "utilize[d]" by "each other agency or person performing review functions" for Medicaid. 42 U.S.C. § 1320c-5(c)(1), (2) (1976).

Thus, in repealing the comprehensiveness requirement and deleting the interim maintenance of effort provision, Congress relieved the states of the obligation eventually to cover all the optional services (42 U.S.C. § 1396d(a)(6)-(16)) and all the medically needy. In the process it reaffirmed the integrity of the basic service package. The comprehensiveness provision was directed only at the gap between mandatory minimum coverage and comprehensive coverage. The 1972 amendments contemplated fiscal relief for the states by permitting them to continue to exclude, or eliminate previously included,

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* *See, e.g.*, 42 U.S.C. § 1396a(a)(26), (30), (31) (1976).

optional eligible persons and services, not by permitting state discretion to limit mandatory services.* (*Compare* St. Br. 47n.25.) The simultaneous passage of PSRO legislation limited the states' obligation under Medicaid to coverage of medically necessary services. The 1972 amendments represented Congress' resolution of the perceived conflict between the needs of the indigent for health care, and the financial limitations on the states. The amendments also resolved any remaining tension between the comprehensiveness mandate and the "necessary medical services" language of 42 U.S.C. § 1396. States were not to cover medically unnecessary care (unless they wanted to do so with their own funds).** The balance that was struck left intact the states' obligation to cover the mandatory services, subject only to the requirement that they be medically necessary.

In 1977 Congress strengthened the PSRO provisions to avoid "disruptive duplicative reviews." H. R. REP. NO. 393 (I), 95th Cong., 1st Sess. 54, *reprinted in* [1977] U.S. CODE CONG. & AD. NEWS 3039, 3056. A PSRO review is "the conclusive determination on" issues of medical necessity "for purposes of payment under this chapter,

* The medically necessary abortion exclusion costs the state money and thereby jeopardizes the provision of other services as well. *See* pp. 59-61 *supra*. But even if excluding medically necessary abortions were cost-saving, this history shows Congress contemplated economic savings by eliminating optional eligibles and/or optional services rather than by eliminating medically necessary care from the mandatory categories, on the basis of diagnosis or condition.

** Where Congress has specifically mandated coverage of services which otherwise might not be medically necessary within the meaning of the Act (*e.g.*, preventive care for children, and non-therapeutic sterilizations as part of family planning, 42 U.S.C. § 1396d(a)(4)), this limitation on the states' obligation does not apply.

and no reviews with respect to those determinations shall be conducted . . . [by] state [Medicaid] agencies." 42 U.S.C. § 1320c-7(c) (1976, *as amended by* Pub. L. No. 95-142, 91 Stat. 1185 (1977)); *see* 42 C.F.R. §§ 463.16(c), 463.27 (1979).*

3. Based on the statutory mandate, HEW has specifically prohibited service restrictions imposed *because* an individual suffers from a particular illness or condition (such as health-endangering pregnancy):

> *Sufficiency of amount, duration, and scope.*
> (a) The plan must specify the amount and duration of each service that it provides.
> (b) Each service must be sufficient in amount, duration and scope to reasonably achieve its purpose.
> (c) (1) The Medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 [cross-referencing to mandatory services for the categorically needy and medically needy] to an otherwise eligible recipient *solely because of the diagnosis, type of illness, or condition.*
> (2) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

42 C.F.R. § 440.230 (1979) (emphasis added).

* States may challenge a PSRO pattern of review determinations only on the basis of "an unreasonable and detrimental impact on total State expenditures under [Medicaid] and on the appropriateness of care received by individuals. . . ." 42 U.S.C. § 1320c-20(d)(3)(A) (1976, *as amended by* Pub. L. No. 95-142, 91 Stat. 1175 (1977)). Only when both conditions exist "with such regularity that program costs were significantly affected" can the state obtain relief, and then only through the Secretary ruling on the state challenge by suspending the binding effect of PSRO decisions. H.R. REP. NO. 673, 95th Cong., 1st Sess. 42, *reprinted in* [1977] U.S. CODE CONG. & AD. NEWS 3113, 3116; *see Greater New York Hospital Ass'n v. Blum*, 476 F.Supp. 234 (E.D.N.Y. 1979).

The regulatory history parallels the statutory history. Medicaid rules were originally contained in the HANDBOOK OF PUBLIC ASSISTANCE ADMINISTRATION, SUPP. D (1967) ("Handbook"). Relying on 42 U.S.C. § 1396a(a)(4), (10), (13), (17), (19) and (22)(D) (Handbook, § D-5110), HEW provided (*id.* at § D-5140) that:

> The medical assistance made available must be sufficient in amount, duration, and scope reasonably to achieve its purpose. A token service which can only be ineffective on the one hand, and wasteful of funds on the other, will not be considered satisfactory.
>
> * * *
>
> *Limitations may not be set by eliminating certain groups of patients or certain diagnoses from coverage* . . . . (emphasis added.)

These Handbook provisions were later superseded by 45 C.F.R. § 249.10(a)(5)(1972). In 1973 HEW issued a proposed revision of 45 C.F.R. § 249.10(a)(5) to "implement certain amendments to Titles XI [PSROs] and XIX [*e.g.*, repeal of comprehensiveness] . . . enacted by Public Law 92-603. . . ." 38 Fed. Reg. 15580 (1973). The proposal included the prohibition against discrimination on the basis of diagnosis or condition but limited that prohibition to discrimination in providing mandatory services. 45 C.F.R. § 249.10(a)(5), 38 Fed. Reg. 15581 (1973). HEW, however, recognized the validity of comments that utilization review and PSRO mechanisms were inconsistent with the proposed total prohibition against limitations based on the diagnosis or type of illness, insofar as medical necessity had become the standard of coverage:

> Comments . . . are:
> The prohibition against limitation on services based on diagnosis is very good; on the other hand, it may undercut utilization review. The regulation has been clarified to indicate that the prescription [*sic*, proscription?] relates to arbitrary limitations, not those appropriate to medical necessity or utilization review.

39 Fed. Reg. 16970 (1974). HEW thus added to the final regulation the proviso that "[a]ppropriate limits may be placed on services based on such criteria as medical necessity or those contained in utilization or medical review procedures," and modified the proposed prohibition against denial on the basis of diagnosis or condition to provide that the state could not "arbitrarily" deny. 39 Fed. Reg. 16971 (1974). The regulation has remained essentially the same ever since,* and HEW has complemented it by instructing the states: "If a PSRO approves services as medically necessary and appropriate and the State denies payment on grounds of lack of medical necessity . . . a question of substantial compliance with the State plan arises and appropriate HEW action will be taken." *Relationship of PSRO Review Responsibilities to the Medicaid Program*, ACTION TRANSMITTAL SRS-AT-76-141 (Sept. 3, 1976), *reprinted in* [1976-1977 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) ¶27,990.

Illinois argues that 42 C.F.R. § 440.230 applies only to those conditions or services which the state chooses "*ab initio*" (St. Br. 52) to include in its program, a position

* In 1978, as part of a general reorganization of Medicaid regulations, HEW republished the regulation as 42 CFR § 440.230 and deleted the word "arbitrarily," as well as the phrase "such criteria as" before the words "medical necessity or utilization control procedures." 43 Fed. Reg. 45228 (1978). When "commentators expressed concern that these omissions have been construed as a policy change," HEW replaced them, noting "the omission of these phrases was not intended to be a policy change." 43 Fed. Reg. 57253 (1978).

which tortures the regulation and reads out of the statute any requirements at all. The regulation explicitly prohibits the state from choosing *ab initio* to discriminate against services for particular diagnoses or conditions, unless such services are medically unnecessary. *See* cases cited at p. 98 *infra*.

Illinois and the intervenors assert that Illinois is not discriminating against a condition, but is excluding one treatment (St. Br. 54; Int. Br. 86). In a program providing services for medical needs, however, refusal to meet particular needs of particular individuals comes only through exclusion of services to treat those needs. That is why 42 C.F.R. § 440.230 refers to denial "of a required service" for particular diagnoses or conditions.

Intervenors also argue that the language allowing "appropriate limitations . . . on services based on *such criteria as* medical necessity" (emphasis added) leaves the state free to place limitations on services for a particular diagnosis or treatment based on a more restrictive definition of medical necessity (*e.g.*, life-threatening) (Int. Br. 87). The "such criteria" language thereby is read to nullify the prohibition—set out in the immediately preceding sentence of the regulation—against exclusions based on condition or diagnosis. In addition, it ignores the historical context of the "such criteria as medical necessity" proviso, which was necessitated by the passage of the PSRO statute. The language "such . . . as" indicates limitations based on equivalent grounds,* not qualitatively different ones. It

* WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY (1976) specifies the following definitions for the adjective "such:"
1a: of a kind or character about to be indicated, suggested or exemplified; . . .
b: having a quality to a degree to be indicated . . .
2a: having a quality already or just specified—used to avoid repetition of a descriptive term. . . .

contemplates distinctions between medically necessary services and medically unnecessary services, and only such distinctions. "Medical necessity" review and "utilization control procedures," 42 C.F.R. § 440.230, both define that distinction. *See* pp. 81-83 *supra*.

HEW has interpreted 42 C.F.R. § 440.230 (and its predecessors) to allow the states to impose durational limits on hospital inpatient care. Handbook, § D-5140. The state and the intervenors see an analogy between HEW's policy and the twenty-one day hospital stay maximum upheld in *Virginia Hospital Association v. Kenley*, 427 F.Supp. 781 (E.D. Va. 1977), and the exclusion of medically necessary abortion services. There is no analogy. HEW's approval of durational limits on such care merely follows the legislative history. Congress explicitly allowed imposition of durational limitations on hospital care, the only type of limitation on mandatory services so contemplated: "the hospital bill shall be paid in full . . . for the number of days covered [by the State program]." H.R. REP. NO. 213, 89th Cong., 1st Sess. 69 (1965); *see id.* at 71; *see also* S.REP. NO. 404, 89th Cong., 1st Sess., *reprinted in* [1965] U.S. CODE CONG. & AD. NEWS 1943, 2019. *Virginia Hospital Association*, relying on HEW's interpretation, 427 F.Supp. at 786, carefully distinguished permissible hospital durational limits from impermissible diagnostic limitations on "*types* of medically indicated" procedures. *Id.* at 785n.2 (emphasis in original). The court found that Virginia's limitation met all or a significant part of the needs of *all* recipients needing inpatient hospital care, regardless of diagnosis, illness or condition. *Id.* at 786.*

* There is no legislative history suggesting that Congress allowed any other type of limitation on coverage of mandatory

(Footnote continued on following page)

As opposed to hospital durational limits, the Illinois policy has no fiscal justification (*see* pp. 59-61 *supra*). It denies medically necessary services based precisely on a recipient's diagnosis, illness or condition, a basis which the statute and 42 C.F.R. § 440.230 prohibit.*

Thus nothing in the legislative history or the regulation supports Illinois' assertion (St. Br. 50) that the frequent references in the statute to "amount, duration and scope" give the state wide latitude in defining those terms for the mandatory services. Except for an irrelevant use of the phrase in 42 U.S.C. § 1396a(a)(2) (1976), every time the phrase appears in the statute it is prefaced by the words "same," "equal" or "shall not be less than," in relation to another eligibility group. Congress thus always used the phrase to define relative coverage between groups (*e.g.*, the medically needy and the categorically needy) and never in the isolated

Footnote continued
services. In this respect, Congress intended the structure of two simultaneously enacted and partially interrelated programs, Medicaid and Medicare (the federal health care insurance program for aged and disabled persons, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395pp (1976 & Supp.I 1977)) to be parallel. Medicare also creates an entitlement to care provided by certain types of providers, so long as the care is "necessary," 42 U.S.C. § 1395y(a) (1976). While Medicare has durational limits, under the heading "Scope of Benefits," 42 U.S.C. § 1395d (1976), that program does not contemplate discriminatory limitations based on diagnosis. "Scope" does not permit exclusions based on diagnosis or condition. *See* 42 C.F.R. § 440.230 ("Amount, duration and scope" of services).

* Illinois, the intervenors and certain amici who rely on durational limits to justify other limits also assume, inconsistently, that states will provide necessary "alternative care" in lieu of medically necessary abortions, even though such "alternative care," if and to the degree effective, requires "prolonged hospitalization," "frequent visits to a physician" and drugs, an optional service. Amicus Brief of Certain Physicians . . . , *passim*; Int. Br. 72-74; St. Br. 41, 54.

context of permitting the state to set the "amount, duration, and scope" of medical services. *See Beal v. Doe*, 432 U.S. 438, 446n.11 (1977).

4. Illinois, the intervenors, and various amici assert that a standard of medical necessity is vague and subject to abuse, and a state may, for that reason alone, use a more restrictive standard.* These assertions are contradicted by the record, and this Court and the lower courts have had no problems with the medical necessity standard for abortions. *E.g.*, *Beal v. Doe*, 432 U.S. 438, 441-42n.3 (1977); *Doe v. Bolton*, 410 U.S. 179, 192 (1973); *United States v. Vuitch*, 402 U.S. 62, 72 (1971); *Women's Health Services, Inc. v. Maher*, Civ. No. H-79-405, slip op. at 16n.12 (D.Conn. Jan. 7, 1980) (vagueness argument is "red herring"); and cases cited at p. 65 *supra*.** The PSRO and utilization review provisions were enacted, in part, precisely to take such judgments about medical necessity away from state administrators. *See* pp. 82-85 *supra*. Medical necessity determinations are to be made on the basis of PSRO norms, and on a case by case basis. In *Association of American Physicians and Surgeons v. Weinberger*, 395 F.Supp. 125 (N.D. Ill. 1975), *aff'd mem.*, 423 U.S. 975 (1976), the court rejected a vagueness attack on the "medically necessary" standard

* *See* St. Br. 15, 40-41, 43-44, 49n.27 ("eludes precise definition"); Int. Br. 22, 76-83 (standard is "loose [and] subject to abuse," "open[s] the door"), and 91 ("elusive"); Amicus Brief of National Right to Life Committee 24-25, 32-33 ("vague and amorphous," "potential for abuse"). Both Amicus Washington Legal Foundation and, arguably, intervenors (Int. Br. 92) predicate their entire legal arguments on this assertion.

** Congress is also comfortable with the standard. The phrase "medical necessity" or medical "need" is used nine times in the PSRO statute (42 U.S.C. § 1320c *et seq.*) and numerous places in Title XIX (*see, e.g.*, 42 U.S.C. §§ 1396a (a)(20), (26)(A), (26)(B), 1396d(h)(1)(B)).

in the PSRO statute. If a PSRO is abusing its responsibility by approving medically unnecessary care, the state's remedy lies with HEW. 42 U.S.C. § 1320c-20(d)(3)(A). Its remedy is not the imposition of a harsh and restrictive standard restricting service for a particular diagnosis or condition, under the guise of preventing abuse in determinations of medical necessity.*

Illinois and the intervenors say, without any support in the record or medical literature (*see* pp. 63-64n *supra*) that there are always equally effective alternative forms of treatment for all conditions and illnesses otherwise requiring medically necessary abortions.** Even were this true, the statute precludes either states or PSROs from choosing between different but medically acceptable methods of treatment; the PSRO-developed norms which are to be applied under 42 U.S.C. § 1320c-5(a)

> with respect to treatment for particular illnesses or health conditions shall include . . . the types and extent of the health care services which, *taking into account differing, but acceptable, modes of treatment and methods of organizing and delivering care are considered within the range of appropriate diagnosis*

* This is not to suggest that any services a physician might deem, under PSRO norms, to be medically necessary must be covered by the state. The state retains the discretion to exclude from coverage *all* optional services. Moreover, the state may retain some discretion to restrict medically necessary services for fiscal reasons by, *e.g.*, the imposition of durational limits on inpatient hospital care or an even-handed, across-the-board restriction on treatment for all conditions (*see* p. 98 *infra*). But the question of what even-handed restrictions on medically necessary services for fiscal reasons might be permitted a state is not presented in this case; the exclusion of almost all medically necessary abortion services is unique in Illinois' program and is not grounded on fiscal concerns (*see* pp. 5-8, 60n *supra*).

** *See* St. Br. 15, 43-44; Int. Br. 70-76, 91; *see also* Amicus Brief of Certain Physicians . . . 2 *passim*.

> *and treatment* of such illness or health condition, consistent with professionally recognized and accepted patterns of care . . . .

42 U.S.C. § 1320c-5(b)(1) (emphasis added).

Illinois and the intervenors also argue that Congress did not intend Title XIX to cover medically necessary abortions because such abortions were illegal in most states in 1965.* *Beal v. Doe*, 432 U.S. 438 (1977), found that a statute whose stated objective was to cover "necessary medical services" could not be held to require coverage of purely elective medical services. This conclusion stood alone based on the face of the statute; it merely was "reinforced" in part by many states' prohibition of elective abortions in 1965. *Id.* at 447. But Congress did not mandate inclusion of any service in the absence of a condition or diagnosis requiring medical treatment.

In contrast, the mandates of the statute and regulations for coverage of medically necessary care cannot be defeated just because in 1965 some states unconstitutionally interfered with women's health. Women requiring medically necessary abortions are suffering from conditions (*e.g.*, sickle cell anemia, retinal eye damage, lung diseases and other conditions described at pp. 13-19 *supra*, complicating pregnancy) which Congress necessarily contemplated covering in 1965; the women had then and they have now conditions necessitating

* In *Beal v. Doe*, 432 U.S. 438 (1977), this Court noted that non-therapeutic abortions were illegal in most states in 1965. Intervenors rely on this reference and the fact that many therapeutic abortions were illegal in many states (Int. Br. 94) to assert that *Beal* thereby redefined "therapeutic." The context in which this Court made its reference, however, dispels any such notion; the Court used the same definitions it has consistently used. *See* 432 U.S. at 441-42n.3, 445n.9.

medical care. In 1965 what may have been for particular women with these conditions the most effective form of *treatment*—an abortion—was illegal in some states. But Congress did not intend the definition of appropriate treatment to be static. At the same time it did intend people with *conditions* for which such care and services were to be provided to have a continuing entitlement to services. Rather than freeze treatment for the poor at 1965 levels, Congress provided in the original Act that development of treatment would be as dynamic as in society at large. 42 U.S.C. § 1396a(a)(22)(D) ("assure that . . . care and services . . . are of high quality"). As this Court said in *Barr v. United States*, 324 U.S. 83, 90 (1945), "[I]f Congress has made a choice of language which fairly brings a given situation within a statute, it is unimportant that the particular application may not have been contemplated by the legislators."

Congress intended Medicaid to move the poor into the mainstream of modern medicine by providing care (and after 1972 only medically necessary care) their doctors prescribed for their conditions under the current state of the art and the law. Relying on 42 U.S.C. § 1396a(a)(22)(D), HEW noted in the Handbook, § D-5144:

> The Congress has made very clear its intent that the medical and remedial care and services made available to recipients under title XIX be of high quality and in nowise inferior to that enjoyed by the rest of the population.

In contrast, Illinois and the intervenors would freeze the right to permissible treatment at 1965 levels, excluding many new surgical techniques (*e.g.*, many forms of heart surgery) and drugs which were unknown or in experimental stages in 1965 but which have since

been approved by the Food and Drug Administration.* There is no support in the statute or legislative history for such a static analysis. Congress has defined the provision of medically necessary services by reference to the general type of care or type of provider (*e.g.*, "physicians' services") and the current state of medical science and law. Thus a state must include "physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title . . .)." 42 U.S.C. § 1396d(a)(5). The cross-reference is to Medicare, which defines a physician with reference to functions he or she is "legally authorized" to perform. 42 U.S.C. § 1395x(r) (1976).** The statute thus reflects an intent to cover the best quality of treatment permitted by law and provided by science. In *Roe v. Wade*, 410 U.S. at 151-52, this Court pointed out that,

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* As early as 1960, in passing Kerr-Mills, it was recognized that treatment would expand. *See* 106 CONG. REC. 16925 (1960) (cost estimates are difficult since "we do not know what changes will take place in medical science") (remarks of Sen. Proxmire); *see also id.* at 17210) (remarks of Sen. Yarborough); H.R. REP. NO. 213, 89th Cong., 1st Sess. 66 (1965). HEW has also rejected stasis. For example, when L-Dopa, a drug for Parkinson's disease, was first approved by the FDA for non-experimental use in 1970, Medicaid and Medicare payments became available for L-Dopa. 3 MEDICARE & MEDICAID GUIDE (CCH) ¶27,201 at 9010-11 (1979). Similarly, HEW requires states to provide transportation to and from medically necessary care. 42 C.F.R. § 431.53 (1979). A combination of legal and scientific developments since 1965 has made such services available to the handicapped. The handicapped's need for medical services was contemplated in 1965; the improvement in "treatment" of this need is subsumed in the intended response to the need.

** Thus, "physicians' services" under Medicaid are those "within the scope of practice of medicine or osteopathy under state law." 42 C.F.R. § 440.50(a) (1979).

originally, the primary purpose of most state laws barring abortions was to protect the health of the pregnant woman in a period during which the state of the art made abortion dangerous. In this case (as opposed to *Beal v. Doe*, 432 U.S. 438 (1977)), abortions are essential for the health of pregnant women. Invalidated state laws, predicated originally on protecting such health, thus hardly support an inference that Congress intended to exclude medically necessary abortions as a treatment methodology for conditions which have always fallen within the statutory compass.*

* Thus no weight should be given to appellants' argument based on Congress' not having expressed a specific intent in 1965 to cover abortions that some state laws barred. (It is equally true that Congress did not then express any intent to exclude abortions that other state laws then permitted.) Congress incorporated a concept of medical need and intended to provide services and treatment to meet such need. This Court has recognized that abortions may often be medically necessary. *Doe v. Bolton*, 410 U.S. 179 (1973); *Beal v. Doe*, 432 U.S. 438 (1977). Since *Roe v. Wade*, 410 U.S. 113 (1973), Congress has amended the Medicaid statute several times (*e.g.*, Act of Dec. 28, 1973, Pub. L. No. 93-233, 87 Stat. 947; Act of Dec. 31, 1975, Pub. L. No. 94-182, 89 Stat. 1051; Act of Oct. 8, 1976, Pub. L. No. 94-460, 90 Stat. 1956; Act of Oct. 18, 1976, Pub. L. No. 94-552, 90 Stat. 2540) without diluting the service coverage provisions of the Act and regulations. The 1977 PSRO amendments reaffirmed the requirement to cover medically necessary services. Any inference drawn from these recent refusals to exclude medically necessary abortions from the substantive requirements of the statute is, to be sure, entitled to limited weight. The inference, however, at worst, is as weighty as the contrary one appellants urge. The applicable factors here are different from those present in *Beal* where no inference could be drawn from Congress' failure to act after 1973 to exclude specific non-therapeutic care from a statute which denied coverage for all such care in any event.

5. HEW has consistently interpreted the Medicaid statute to allow states to exclude elective abortions, but require states to cover medically necessary abortions as defined in *Doe v. Bolton*, 410 U.S. at 192. *See* U.S. Br. 43-44n.23; *Memorandum for the United States as Amicus Curiae*, in *New York State Department of Social Services v. Klein*, U.S. Sup.Ct. Nos. 72-770 and 72-803 (filed May, 1973) at 5-7; *Memorandum for the United States as Amicus Curiae* in *Beal v. Doe*, U.S. Sup.Ct. No. 75-554 (filed March, 1976) at 5n.*

Similarly, virtually all courts considering the question, including four federal courts of appeals, have held that exclusions of medically necessary abortions violate the Medicaid statute. Some have held that any limitation on medically necessary care within the mandatory services violates the Act: *Doe v. Busbee*, 471 F.Supp. 1326 (N.D. Ga. 1979); *Roe v. Casey*, 464 F.Supp. 487 (E.D. Pa. 1978); *Right to Choose v. Byrne*, 398 A.2d 587 (N.J. Super. 1979).** Others have held that some even-handed, fiscally-based, across-the-board limitations on medically necessary care may well be permissible, but that a restrictive standard applied to

* HEW's failure to disapprove state Medicaid plans which include impermissible abortion limits (Int. Br. 95n.42) is not inconsistent, since it has no significance. *See, e.g., T___H___ v. Jones*, 425 F.Supp. 873 (D. Utah 1975), *aff'd mem.*, 425 U.S. 986 (1976); *Smith v. Vowell*, 379 F.Supp. 139, 161 (W.D. Tex. 1974) (court should not make "grave mistake . . . of equating [HEW] inaction with actual approval").

** The courts have applied this same principle to mandatory services in the non-abortion context. *See Rush v. Parham*, 440 F.Supp. 383 (N.D. Ga. 1977); *Smith v. Vowell*, 379 F.Supp. 139 (W.D. Tex. 1974), *aff'd mem.*, 504 F.2d 759 (5th Cir. 1974). *See also American Medical Ass'n v. Weinberger*, 395 F.Supp. 515 (N.D. Ill.), *aff'd*, 522 F.2d 921 (7th Cir. 1975).

medically necessary abortions is illegal because it discriminates on the basis of diagnosis and condition and thereby violates some or all of the following provisions: 42 U.S.C. § 1396a(a)(10)(B), (C)(ii), (17), (19), and 42 C.F.R. § 440.230. *Preterm, Inc. v. Dukakis*, 591 F.2d 121, 124-25 (1st Cir. 1979); *Women's Health Services, Inc. v. Maher*, Civ. No. H-79-405, slip op. at 6 (D.Conn. Jan. 7, 1980).* A third group articulates both positions or finds it unnecessary to resolve the issue since a restriction on medically necessary abortions patently violates the Act under either reading. *Hodgson v. Board of County Commissioners*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶ 30,159 at 10,072 (8th Cir. Jan. 9, 1980); *Reproductive Health Services v. Freeman*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,160 at 10,082 (8th Cir. Jan. 9, 1980); *Zbaraz v. Quern*, 596 F.2d 196 (7th Cir. 1979) (U.S.J.S. App. 42a); *Doe v. Kenley*, 584 F.2d 1362, 1366 (4th Cir. 1978) (*dictum*); *McRae v. Secretary of HEW*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,155 at 10,042-43 (slip op. at 296) (E.D. N.Y. Jan. 15, 1980); *Planned Parenthood Affiliates of Ohio v. Rhodes*, 477 F.Supp. 529, 537 (S.D. Ohio 1979); *Emma G. v. Edwards*, Civ. No. 77-1342-B, slip op. at 4 (E.D.La. 1978); *Smith v. Ginsberg*, Civ. No. 75-0380 CH, slip op. at 3 (S.D. W.Va. May 9, 1978).

The state and the intervenors rely on two district court cases. *District of Columbia Podiatry Society v. District of Columbia*, 407 F.Supp. 1259 (D.D.C. 1975), involved an optional service and involved no discrimination since the District "permit[ted] physicians to furnish a full range of podiatric care." 407 F.Supp. at 1262-63.

* *See also White v. Beal*, 555 F.2d 1146 (3d Cir. 1977); *Dodson v. Parham*, 427 F.Supp. 97 (N.D. Ga. 1977); *Curtis v. Page*, [1979 Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) ¶ 29,649 (N.D. Fla. 1979) (invalidating discriminatory exclusions unrelated to medical necessity).

All medically necessary services were covered, regardless of diagnosis or condition. The second case, *D___R___ v. Mitchell*, 456 F.Supp. 609 (D.Utah 1978), is a judicial anomaly, upholding Utah's exclusion of medically necessary abortions.* *D___R___* relies heavily on *Beal*'s reference to the state's interest in "normal childbirth" for justification. This misconstrues *Beal*. A woman with no medical need for an abortion can be presumed by the state to be capable of going through normal childbirth.** The same cannot be said of a woman with a medical need for an abortion.

Title XIX prohibits precisely what Illinois has done here. Both HEW and the courts have confirmed that Title XIX requires the states to cover medically necessary abortion services.

C. The Hyde Amendment Does Not Impliedly Relieve Illinois Of Its Duty Under The Social Security Act To Cover All Medically Necessary Abortion Services.

The court of appeals held that the FY 1978 Hyde Amendment operated substantively to amend Title XIX so as to permit Illinois to deny medically necessary abortion services the Act would otherwise require it to cover. This holding has provoked an extraordinary variety of responses from appellants, none of whom supports the court of appeals' position.

* The court of appeals subsequently entered an injunction pending appeal requiring Utah to cover medically necessary abortions to the extent of the Hyde Amendment. *D___R___ v. Mitchell*, No. 78-1675 (10th Cir. Oct. 25, 1979).

** Again, "normal childbirth" qualifies the state's interest in potential life and demography, interests which in any event are not served by the Medicaid program. Medicaid requires states to cover family planning services, to serve "the best interests of the *recipients*" (emphasis added), and to provide medically necessary care. *See* pp. 56-58 *supra*.

Appellees urge that the Hyde Amendment must be read to mean what it says—to affect only the use of federal funds, and not by implication to alter the coverage requirements of Title XIX. Intervenors likewise read the Hyde Amendment not to have affected the coverage requirements of Title XIX; their quarrel with appellees is over the interpretation of Title XIX, which they read to permit states not to fund *any* abortions. Illinois' position appears to be that the Hyde Amendment *forbids* states—on pain of disqualifying their entire state plans—from funding abortions they formerly were free to fund.* And the United States, while purporting "not . . . to disavow the court of appeals' . . . analysis," nevertheless questions whether the Hyde Amendment worked a "substantive change" in the Medicaid statute (U.S. Br. 47n.27). The United States asserts that Title XIX implicitly is structured never to require states to cover procedures for which federal financial participation is unavailable.

This bewildering variety of opinions itself provides a powerful argument for appellees' position. Appellants and the court of appeals as well purport to find support for their respective positions in the legislative history of the Hyde Amendment (*see* pp. 106-21, 128-29 *infra*). In combination they dramatically demonstrate how precarious it is to try to infer anything about the effect on an es-

* Appellees understand this to mean that states would be barred from receiving federal money for any part of their Title XIX plans if they fund non-Hyde Amendment abortions. If the State means only that federal funds would be unavailable for non-Hyde Amendment medically necessary abortions, then its position on the effect of the Hyde Amendment is identical to that of appellees. But the State argues that the Hyde Amendment did work a substantive change in Title XIX by eliminating pre-existing discretion to cover abortions (St. Br. 56-58), so that it must intend the more far-reaching position.

tablished and complex substantive statute from heated and unfocused debates on appropriations for an isolated corner of that statute.

The successive Hyde Amendments* say only that "none of the funds provided [for] in the [HEW appropriations] Act[s] shall be used" for medically necessary abortions, except in extremely narrow circumstances. The Amendment includes no reference to Title XIX, much less to the services Title XIX requires states to provide as a condition of participation in the Medicaid program. Nothing on the face of the statutes suggests that Congress meant to do anything other than limit federal reimbursement for services Title XIX otherwise requires a state to cover as a condition of federal support generally for its Medicaid program. The "most persuasive evidence" of Congress' intent in enacting the Hyde Amendment—the "words by which . . . [it] undertook to give expression to its wishes," *United States v. American Trucking Associations, Inc.*, 310 U.S. 534, 543 (1939), provides no support for the conclusions that the Hyde Amendment was meant impliedly to repeal the substantive coverage requirements of Title XIX or to dovetail with some existing understanding

* The FY 1980 Hyde Amendment now in force differs from the previous provisions, including the one the court of appeals had before it (*see* U.S. Br. 50-51) but not in any way that affects the present analysis, except insofar as the constant change in provisions suggests the mischief in holding annual appropriations legislation recurrently to change substantive provisions of a statute imposing obligations on a state. *See Hodgson v. Board of County Comm'rs*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,159 at 10,078 (8th Cir. Jan. 9, 1980) (McManus, J. dissenting); *D.C. Federation of Civic Ass'ns v. Airis*, 391 F.2d 478, 482 (D.C. Cir. 1968). No party suggests that Congress' intent in passing the successive amendments has differed from year to year so as to require any varying analyses of their impact.

that federal funding limitations modify Title XIX. Accordingly, the appellants' and court of appeals' conclusions to this effect are all predicated on an argument that Congress expressed its will by implication. *See* pp. 121-122, 124 *infra*.

In *TVA v. Hill*, 437 U.S. 153 (1978), this Court recently rejected a strikingly similar argument. *TVA* held that an appropriations provision for completion of a public works project threatening the habitat of an endangered species did not amend a substantive statute protecting that habitat. The decision reaffirmed and applied three longstanding principles of statutory construction. The first is that "there must be something to make plain the intent of Congress that the letter of the statute is not to prevail." *Id.* at 187n.33. The second is a "cardinal rule" that an "intention of the legislature to repeal [a statutory provision] must be clear and manifest," *id.* at 189; "in the absence of some affirmative showing of an intention to repeal, the only permissible justification for a repeal by implication is when the earlier and later statutes are irreconcilable." *Id.* at 190. The third is that this "cardinal rule . . . applies with even greater force when the claimed repeal rests solely on an Appropriations Act." *Id.* at 190.* *See also United States v. Langston*, 118 U.S. 389, 393 (1886) ("If by any reasonable construction they [the pre-existing substantive legislation and the appropriations rider] can be made to stand together our duty is to give effect to the provisions of each").

* A fourth principle, not present in *TVA* but present here, is that courts should, if possible, construe a statute in a way which will avoid the constitutional question otherwise presented. *Ashwander v. TVA*, 297 U.S. 288, 348 (1935) (Brandeis, J. dissenting in part). *See Doe v. Mathews*, 422 F.Supp. 141, 147 (D.D.C. 1976) (applying avoidance doctrine to interpretation of the Hyde Amendment).

The court of appeals avoided the fact that the Hyde Amendment and Title XIX are not irreconcilable; and no appellant argues for irreconcilability. Appellants seek instead to establish from the legislative history of the Hyde Amendment Congress' "clear and manifest" intent impliedly to repeal.

Initially, however, there should be no occasion to consult those debates at all. The language of the Hyde Amendment is clear, and "[w]hen confronted with a statute which is plain and unambiguous on its face," this Court does not "ordinarily . . . look to legislative history as a guide to its meaning." *TVA v. Hill*, 437 U.S. 153, 184 (1978).

The court of appeals' reasons for departing from this rule are unpersuasive. Initially it asserted that state obligations under Title XIX are "not all . . . clearly spelled out in that statute . . . . " *Zbaraz II*, U.S.J.S. App. 45a. The only sense in which this is true, however, is that Title XIX often imposes obligations on states in general terms and through the interaction of different provisions of a complex statute. But generality in statutory requirements (such as Title XIX or the Endangered Species Act) is a commonplace, so that reliance on that factor would undercut the very rule the court of appeals recognized as entitled to respect. The complexity of the Medicaid statute merely reinforces the arguments for avoiding disruptive interference with the statutory scheme by legislative action that is not focused on that very complexity. The court of appeals itself conceded that its approach "enhances the likelihood of confusing and disruptive annual changes . . . ." *Id.* at 44a.

The court of appeals also regarded it as significant that "these obligations arise in the context of a plan for sharing expenses between federal and state

governments." U.S.J.S. App. 45a. The suggestion, apparently, was that for Congress not to repeal the requirement that the states fund all medically necessary abortions, when it provides no matching funds for all these abortions, is so "absurd" a result that review of the legislative history is justified to determine if Congress really intended that result. *See TVA v. Hill*, 437 U.S. 153, 184n.29 (1978). As discussed at pp. 123-28 *infra*, however, the reality is that funding formulas in federal-state cooperative programs, including the Medicaid program, often fail to track substantive obligations; and giving the Hyde Amendment the meaning its words express produces a result that is supported by precedent and logic, and is even to be expected, given the realities of the legislative process.

If it is nonetheless appropriate to look at the legislative history of the Hyde Amendments to ascertain the reach of those provisions, none of the appellants finds in them the necessary support. Nor does that history support the court of appeals.

Normally this Court relies on committee and conference reports, which derive from legislators with responsibility for the legislation, as authoritative statements of legislative intent. These reports are available to all legislators when voting on a bill, and often serve to guide and focus debate.

There are no committee or conference reports bearing on the question here. There are, indeed, only two collective expressions of legislators' intent. One is a "Joint Explanatory Statement of the Committee of Conference" on the FY 1977 HEW Appropriations bill. The brief state-

ment, paralleling the language of the Hyde Amendment itself, supports appellees.*

The second collective statement came in response to HEW's promulgation of regulations as required by the FY 1978 Hyde Amendment, which instructed HEW to issue regulations insuring that the provision be "rigorously enforced." Pub. L. No. 95-205, § 101, 91 Stat. 1460 (1977). The responsive regulations, by their express terms, address only the issue of "Federal financial participation . . . ." 43 Fed. Reg. 4570 (Feb. 2, 1978). After the promulgation of the regulations, fifty Congressmen who had supported the Hyde Amendment, including Rep. Hyde, wrote a letter to the Secretary of HEW (124 CONG. REC. S18439-40 (daily ed. Oct. 12, 1978)), stating that "the purpose of this resolution [the Hyde Amendment] is to limit HEW funding for abortions" (*id.* at S18439) and criticizing the regulations for "violat[ing] the intent, purpose and spirit of the law." *Id.* That letter detailed the many respects in which the signatories

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* Section 209 of the House bill contained a prohibition against the use of funds contained in this Act to pay for or to promote or encourage abortions. The Senate bill deleted this provision.

Having met in further conference, agreement has been reached on the issue of whether or not Federal funds may be used to finance abortions. Most certainly, this is a difficult, emotionally-charged issue—one which many believe should be dealt with by the appropriate legislative committees.

* * *

It is the intent of the Conferees to limit the financing of abortions under the Medicaid program to instances where the performance of an abortion is deemed by a physician to be of medical necessity and to prohibit payment for abortions as a method of family planning, or for emotional or social convenience.

H.R. REP. NO. 1555, 94th Cong., 2d Sess. 3 (1976).

believed the Secretary had not faithfully enforced the provisions of the rider; the signatories wrote that he had not promulgated "tight regulations that would have effectively limited federal funding to abortions that actually fit within the stipulations of the law as intended by Congress." *Id.* at S18440. But nowhere is there any criticism of the Secretary's failure to enforce the Amendment by a statement in the regulations that it was intended to alter a state's obligation to cover most medically necessary abortions.

The court of appeals' holding is not based on any collective legislative expression. It is based solely on the floor debates, which this Court consistently has recognized are of limited usefulness. "In construing laws we have been extremely wary of testimony before committee hearings and of debates on the floor of Congress save for precise analyses of statutory phrases by the sponsors of the proposed laws." *S & E Contractors v. United States*, 406 U.S. 1, 13n.9 (1972); *see Planned Parenthood Affiliates of Ohio v. Rhodes*, 477 F.Supp. 529, 539 (S.D. Ohio 1979).

The court of appeals purported to find from the debates that the "overwhelming weight of the legislative history" supported its conclusion of a substantive change. U.S.J.S. App. 49a. Others have found the debates far less clear. The introductory comments to the HEW regulations concluded that the debates were "inconsistent or inconclusive" and lacked any "official expression of even one House of Congress as to the meaning of this statute." 43 Fed. Reg. 4833 (Feb. 2, 1978). In February, 1978, in a letter written to HEW Secretary Califano, Attorney General Bell noted the difficulty in interpreting the Hyde Amendment: "for the most part, neither the language of the section nor its

legislative history provides clear answers." *Departments of Labor and HEW Appropriations for 1979: Hearings before the Subcommittee on the Departments of Labor and HEW of the House Committee on Appropriations*, 95th Cong., 2d Sess., Pt. 2, at 70 (Feb. 21, 1978) (statement of Joseph A. Califano). Secretary Califano stated before a House appropriations subcommittee that HEW's interpretation of the Hyde Amendment was difficult because there was "lots of difficulty, language not clear, lots of contradictory elements in the debate itself." *Id.* at 174.

In fact, the court of appeals' conclusion of implied repeal could only have been reached "through strained process of deduction from excerpts of wholly ambiguous significance, . . . furnish[ing] dubious bases for inference in every direction." *Gemsco v. Walling*, 324 U.S. 244, 260 (1944). Neither that court nor any appellant cites a single comment specifically expressing an intention to repeal the requirement that states cover medically necessary abortions. In fact there is one such unambiguous statement—and apparently only one—in the several hundred pages of debates. Rep. Russo said in the FY 1978 debates that under the Hyde Amendment, states would have the option of paying for abortions, but the withdrawal of federal funding would encourage them to discontinue abortion coverage, "an option States cannot exercise at the present time." 123 CONG. REC. H6097-98 (daily ed. June 17, 1977). This remark, standing alone, hardly meets the *TVA* test; rather it demonstrates that it was possible for legislators to articulate such an intent—and with this exception they apparently did not.

In contrast, the debates contain a great deal that supports precisely the conclusion that the language of the Amendment suggests. Most members of Congress par-

ticipating in the debates, including all the most prominent supporters of the successive Amendments, repeatedly and from the outset described the Hyde Amendment as being intended to restrict federal funding for abortions. Representative Hyde himself, in debates over the FY 1977 rider, stated that he "intended to prevent the use of Federal funds to pay for abortions except to save the life of the mother. I offer this as a clear statement of legislative intent." 122 CONG. REC. 30897 (1976).*

Rep. Bauman led the fight in the House for adoption of the riders. Speaking in support of the FY 1977 Amendment, he stated that it would "simply prevent the use of taxpayers' funds to finance and promote abortion." 122 CONG. REC. 26789 (1976).** Rep. Flood, floor

* Rep. Hyde referred to the Hyde Amendment in the same terms on several occasions: "We . . . seek to inhibit the use of Federal funds to pay for and thus encourage abortion . . . ." 122 CONG. REC. 20410 (1976); "[t]he position [the House] has adopted . . . is that Federal money shall not go to pay for the taking of innocently inconvenient life . . . . The position is that no Federal funds go to pay for abortion," 123 CONG. REC. H10830 (daily ed. Oct. 12, 1977); compromise provision unacceptable because it "result[s] in Federal funding of some abortions, and this is a position that I must resist and that I cannot accede to," 125 CONG. REC. H9885 (daily ed. Oct. 30, 1979).

** Rep. Bauman and other supporters often expressed their understanding of Congress' intent as the *prohibition* of "public" funds or "tax" dollars for abortions, without specifying whether they were referring to federal or state moneys. *See, e.g.*, 122 CONG. REC. 20411 (1976) ("prohibit the use of tax dollars for the payment for the performance of abortions") (Rep. Kindness); 123 CONG. REC. H6090 (daily ed. June 17, 1977) ("We can constitutionally prohibit the use of tax dollars to promote and perform abortions") (Rep. Volkmer); *id.* at H6096 ("Hyde Amendment . . . forbid[s] funding for all abortions under Medicaid") (Rep. Oakar); *id.* at H8348 (daily ed. Aug. 2, 1977) ("prohibits the use of any funds for abortions ex-

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manager of the conference report on the FY 1978 Labor-HEW appropriations bill, expressed his understanding of the debates as involving the "issue of Federal funds for abortions." 123 CONG. REC. H10866, H10829 (daily ed. Oct. 12, 1977); *see also* 122 CONG. REC. 30895 (1976). Rep. Rudd, a consistent supporter, stated in debates over the FY 1980 rider that "the question before us today, as on so many previous occasions, is that of the appropriate extent of Federal funding for abortions." 125 CONG. REC. H5261 (daily ed. June 27, 1979).

In the Senate, Senators Helms, Hatch and Bartlett were among the most prominent spokesmen for passage of the Amendments, and Sen. Brooke was their most prominent opponent. Sen. Helms characterized the FY 1979 rider as a "decision to restrict the use of Federal funds for abortion . . .," 125 CONG. REC. S9853 (daily ed. July 19, 1979), and "an agreement between the Senate and the House that Federal funding of abortions should be strictly limited . . . ." 124 CONG. REC. S18443 (daily ed. Oct. 12, 1978). He objected to a less restrictive version as "mandat[ing] the expenditure of Federal taxpayers' money to pay for the performance of abortions . . . ." 123 CONG. REC. S18584 (daily ed. Nov. 3, 1977). During passage of the FY 1977 Hyde Amendment he stated, "The intent of this provision is clear. It is to restrict the

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cept to save the life of the mother") (Rep. Hyde); 125 CONG. REC. H5254 (daily ed. June 27, 1979) ("[the] bill . . . only says the taxpayers money will not be used [for abortions]") (Rep. Volkmer). None of these legislators ever suggested that Congress constitutionally could "prohibit" the states from funding abortions with their own "tax" dollars. Thus, when these legislators suggested that the Hyde Amendment was intended to "prohibit" "tax" funding of most abortions, they most reasonably are understood as referring to the federal government and the federal tax dollars that were their legislative business.

use of Federal money for abortion." 122 CONG. REC. 30996 (1976). Sen. Hatch, speaking in favor of the FY 1980 rider, said that the Congressional supporters of the rider were a "bipartisan majority—[which] opposes Federal funding of abortion." 125 CONG. REC. S9853 (daily ed. July 19, 1979). Their fight, he stated, had been "waged in opposition to Federal funding of abortions." *Id.* Sen. Bartlett said that "the purpose of the [FY 1978] amendment is very clear, to stop the Federal financing of abortions." 123 CONG. REC. S10803 (daily ed. June 27, 1977). Sen. Brooke said that the FY 1977 rider "rule[d] out all abortions at Federal expense. That is what the Hyde Amendment intended to do and that is exactly what it does." 122 CONG. REC. 27764 (1976).

The court of appeals dismissed this legislative history by saying that only "a few Congressmen and Senators said that the amendment would simply restrict federal funds for abortions." *Zbaraz II*, U.S.J.S. App. 45a. In fact, the remarks quoted above are only a small sample of remarks in the same vein.*

* *See, e.g.*, 122 CONG. REC. 30896 (1976) ("Hyde Amendment . . . as passed by this House prohibited the use of Federal funds for abortion") (Rep. Conte); *id.* at 30899 ("Make no mistake about it, this language makes the intent of Congress very clear. We are not going to permit the Federal Government and its taxpayers to support wholesale murder") (Rep. Bauman); *id.* at 27673 ("Specifically the question is one whether we should permit Federal funds through the Medicaid program to be utilized by women who need or require abortions") (Sen. Bayh); *id.* at 26786 ("we must decide whether . . . to support Mr. Hyde's proposal to prohibit Federal tax dollars from being used to promote or perform abortion") (Rep. Paul); *id.* at 20885 (the question is whether there is "an affirmative duty on the part of the Federal Government to use public funds to finance the termination of human life") (Sen. Helms); *id.* at 33868 (Hyde Amendment is "unconscionable limitation on the use of Federal funds for abortions") (Sen. Packwood); 123 CONG. REC. H6090 (daily ed.

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June 17, 1977) ("Once again the Congress must make a decision on the Federal funding of abortions") (Rep. O'Brien); *id.* ("the only thing that we can address ourselves to in this body, and the only thing over which we have any control, is what we do with Federal dollars. That is why this question centers on the area that it does") (Rep. Edwards); *id.* at S10177-78 (daily ed. June 20, 1977) ("it is morally wrong to use Federal tax dollars for having abortions performed on demand. There is just no justification for the Federal Government to pay for such abortions . . . . I believe that the prohibition against using Federal funds for abortions which we included in the appropriations bill last year should also be included in the fiscal year 1978 appropriations bill") (Sen. Stennis); *see also id.* at S11039-40 (daily ed. June 29, 1977) (Sen. Stennis); *id.* at S11039 ("The question now before the Congress, the so-called Hyde Amendment is whether or not Federal funds may be used in welfare cases to pay abortion-related costs in certain circumstances") (Sen. Bellmon); *id.* at H10134 (daily ed. Sept. 27, 1977) ("In two separate Congresses, in 1976 and 1977, the House has cleaved to the language of the Hyde Amendment which prohibits the Federal funding of abortions unless it is to save the life of the mother") (Rep. Dornan); *id.* at H12174 (daily ed. Nov. 3, 1977) ("The debate [is] on the question of Federal funds for abortion") (Rep. Neal); *id.* at S18589 (daily ed. Nov. 3, 1977) ("I will no longer be able to support my colleagues in their efforts to find a provision restricting Federal funds for abortions which will be acceptable to the House . . . . When the issue first arose this year, I took the strong position that the Federal Government should provide funds for all medicaid abortions") (Sen. Packwood); *id.* at S18791 (daily ed. Nov. 4, 1977) ("For those who are totally opposed to Federal funding for abortions, and those who feel that there should be far more Federal funding for abortions, it [FY 1977 compromise version of Hyde Amendment] is not really totally acceptable to either side . . . .") (Sen. Leahy); 124 CONG. REC. H5358 (daily ed. June 13, 1978) ("throughout the prolonged debate on this issue of whether or not Federal taxpayers' money should be spent to finance abortions, on no occasion has the House . . . ever adopted a proposition similar . . . that we have no restrictions whatever on Federal funding of abortions") (Rep. Bauman); *id.* at H5360 ("I support the Hyde Amendment prohibiting the use of Federal taxpayer dollars to perform abortions. . . . [W]e [must] do everything in our power to stop the use of Federal dollars to perform abortions") (Rep. Rudd); 125 CONG. REC. H5213 (daily ed. June 27, 1979) ("this [proposed procedural rule] is an effort to save time and at the

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These remarks, both in bulk and in the authority of the speakers, reinforce the interpretation the words of the Hyde Amendment alone would lead to.* In contrast,

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same time to be fair to all parties in the House, those who support Federal funding of abortions and those who oppose it, as I do") (Rep. Bauman); *id.* at H5257 ("we should point out that we are not asking the question whether or not abortion should be permitted under the enumerated circumstances. The question we are being asked to vote on is whether or not we should provide Federal funds for and thereby endorse abortion under these circumstances") (Rep. Tauke); *id.* at H8762 (daily ed. Sept. 28, 1979) ("we firmly stood by the House position, which restricts the use of Federal funds for abortion except where the life of the mother would be endangered if the fetus were carried to term") (Rep. Whitten); *see also id.* at H8855 (daily ed. Oct. 9, 1979) (Rep. Whitten); *id.* at H10955 (daily ed. Nov. 16, 1979) (Rep. Whitten); *id.* at H9884-85 (daily ed. Oct. 30, 1979) ("because it would prohibit the use of any Federal funds to perform abortions except where the life of the mother is endangered or where rape or incest has occurred, I believe it is language that the House could embrace . . .") (Rep. Wright); *id.* at H10959 (daily ed. Nov. 16, 1979) ("we began this whole dialogue on the issue of abortion as a result of our finding out there were a considerable number of abortions being funded by the Federal Government. Those of us opposed to that initially subscribed to what was called the first Hyde Amendment, which specified that 'none of the funds shall be used to perform abortions.' Period. That is where the House started out several years ago") (Rep. Michel).

* The court of appeals had before it only the FY 1977 and FY 1978 Hyde Amendment debates. In dismissing the "few" comments of this nature that it acknowledged, the court characterized them as "apparently intended to distinguish between a prohibition on abortions (which would be unconstitutional . . .), and a mere refusal to fund abortions." *Zbaraz II*, U.S.J.S. App. 45a. Some of those commenting on federal funding restrictions did distinguish the question of whether abortions could be prohibited, from that of whether the federal government should fund them, *e.g.*, 125 CONG. REC. H5257 (daily ed. June 27, 1979) (Rep. Tauke). But most made no such distinction. In any event, the relevant distinction the legislators should have drawn, for the court of appeals to have been correct, was that between federal funding of abortions and required coverage of abortions under Medicaid.

appellants and the court of appeals cite no explicit authority to meet their burden under *TVA*. Those remarks affirmatively suggesting that a restriction on the use of federal funds would be the *only* effect of the Hyde Amendment are more frequent than specific contrary suggestions of intent to repeal by implication.*

* Sen. Stevens, minority whip, said that the FY 1977 rider "only deals with who pays the bill, whether it is the Federal Government or the State Government." 122 CONG. REC. 30990 (1976). "[W]hat we are talking about is not legislation as to whether or not there would be an abortion but legislation to determine what is the fair burden sharing between the Federal Government and the State Government with regard to payments for abortions which take place under State law without regard to the bill we have considered." *Id.* Speaking against a proposed restrictive abortion rider to the Department of Defense appropriations bill, Sen. Stevens compared the impact of the rider to those previously attached to the Labor-HEW appropriations acts, stating that because the federal government alone had assumed the obligation to provide medical services to armed forces personnel, the restrictive rider would itself limit the provision of these services. 125 CONG. REC. S15975 (daily ed. Nov. 6, 1979). But "[i]n the other circumstances, when we were dealing with HEW, we were talking about who should pay. Should a state pay or should the Federal government pay." *Id. See also* remarks of Sen. Stevens, *id.* at S16712 (daily ed. Nov. 15, 1979); *id.* at S13737 (daily ed. Sept. 28, 1979); 122 CONG REC. 30990 (1976). Rep. Smith was a supporter of the riders. He stated, "[A]ll we are talking about really is whether or not we will refund to the States a few hundred thousand dollars per year. It will make no difference whatever in the number the States pay for, but will reduce by a few the number for which they receive reimbursement. That is all we are talking about." 125 CONG. REC. H5257 (daily ed. June 27, 1979). Sen. Eagleton, also a supporter, said that "[d]ecisions have been made over the years as to what medical services are and are not covered through Federal funds. The Hyde Amendment is simply another limitation on what services will be covered by Federal funds." *Id.* at S9860 (daily ed. July 19, 1979). And Sen. Magnuson, a member and later chairman of the Senate Appropriations Committee, characterized the entire debate over the FY 1977 rider as an "argument over whether the State should handle [funding of abortions] or the national government." 122 CONG. REC. 19439 (1976).

And while it is not surprising that legislators would fail to mention effects they were not intending to bring about, it is startling to find an intent to repeal by implication when nobody—with the apparently lone exception of Rep. Russo—declared such an intent. *Compare TVA v. Hill*, 437 U.S. at 191-93, where several Congressmen and Senators on the House and Senate appropriations committees with jurisdiction over appropriations for TVA specifically expressed their view that the Endangered Species Act did not prevent completion of the Tellico Dam. If the history there did not "affirmative[ly] show" an intent to repeal, 437 U.S. at 190, Congress' intention to repeal the states' obligations under Title XIX can hardly be found in the Hyde Amendment debates.

With no remarks specifically declaring Congress' intent to repeal, the court of appeals supported its conclusion of a substantive change on the basis that some supporters and opponents of the Hyde Amendment assumed that when federal funding for most medically necessary abortions was withdrawn, the states similarly would restrict abortions. *Zbaraz II*, U.S.J.S. App. 46a. The flaw in the court of appeals' approach is that this expectation of some legislators appears to have flowed not from an intent to change Title XIX, but from inattention to, indifference to, or confusion about, what Title XIX requires. The silence in the debates respecting the legal relationship between the Hyde Amendment and Title XIX strongly suggests that the legislators participating in the debates had not formed, much less shared, any specific intent or understanding at all regarding the relationship between the Hyde Amendment and Title

XIX.* Most legislators undoubtedly brought with them to the "emotional floor debates" (*Zbaraz II*, U.S.J.S. App. 45a) deeply held feelings about abortion, *McRae v. Secretary of HEW*, No. 76 C 1804, slip op. at Annex *passim* (E.D.N.Y. Jan. 15, 1980); and all presumably brought with them a general understanding that the Hyde Amendment incorporated an anti-abortion position. The intensity and substance of most legislators' remarks can be explained by reference to these concerns and that understanding alone; they spoke, as legislators not uncommonly do, without focusing on the specific statutory questions which later become relevant in cases coming before the courts. *See Jewell Ridge Coal Corp. v. Local 6167, UMW*, 325 U.S. 161, 169-70 (1945); *National Nutritional Foods Association v. FDA*, 504 F.2d 761, 780-81 (2d Cir. 1974) (Friendly, J.).

The same points can be made with regard to other convoluted inferences drawn by the court of appeals. Relying on the "frequently reiterated belief . . . that taxpayers ought not to be compelled by the federal government to finance abortions which were repugnant to them on religious or moral grounds," the court of appeals stated that "[t]his concern *would apply* with at least equal force if the tax expenditures required by federal law came from the state rather than the federal treasury." *Zbaraz II*, U.S.J.S. App. 46a (emphasis add-

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* A few legislators speaking in support of the FY 1980 rider were later to construe such silence as incorporating a presumption that the Act had never required coverage of abortions at all. The intervenors rely on such comments (discussed at pp. 120-21 *infra*) to support their understanding of Title XIX (Int. Br. 97-99). But those remarks, coming after court decisions interpreting Title XIX to require funding of all medically necessary abortions or Hyde Amendment abortions, were in all likelihood simple attempts to rewrite earlier legislative intention. *See* pp. 120-21n. *infra*.

ed). The question is not which concerns "would apply," but what legislators said. Moreover, most legislators expressing the type of "belief" on which the court of appeals relied, specifically addressed the compulsory use of "federal" tax dollars, spent by the "federal government."* These references are fully consistent with

* Even some of the excerpts from the debates to which the court of appeals referred (U.S.J.S. App. 47a, n.13) are ones in which legislators explained their views in this way, *viz*: 123 CONG. REC. H6084-85 (daily ed. June 17, 1977) (Rep. Obey); *id.* at H10835 (daily ed. Oct. 12, 1977) (Rep. Early); *id.* at S18584-85 (daily ed. Nov. 3, 1977) (Sen. Helms); *see also id.* at S11038 (daily ed. June 29, 1977) ("I think it is a moral crime that 300,000 [abortions per year] have been paid for by Federal tax dollars, much of which have been paid into the Federal treasury by people who do not believe in abortion for purely religious grounds or for moral reasons") (Sen. Hatch); 124 CONG. REC. H5358 (daily ed. June 13, 1978) ("throughout the prolonged debate on this issue of whether or not Federal taxpayers' money should be spent to finance abortion, on no occasion has the House of Representatives ever adopted a proposition similar to one proposed today by the gentleman from Ohio [Mr. Stokes], that we have no restrictions whatsoever on Federal funding of abortions") (Rep. Bauman); 125 CONG. REC. H5233 (daily ed. June 27, 1979) ("This language keeps the Federal Government out of the business of financing abortions. . . . This House should not force those taxpayers who are morally opposed to abortion, to foot the bill for them") (Rep. Luken); *id.* at S9852 (daily ed. July 19, 1979) ("I think of the millions of people across this country who do not want their money to be spent by the Federal Government to deliberately terminate the life of an innocent human being") (Sen. Helms).

To be sure, some legislators who objected to requiring taxpayers morally opposed to abortion to pay for it spoke in terms of the "taxpayers of this Nation," 123 CONG. REC. S11039 (daily ed. June 29, 1977) (Sen. Stennis), or simply "the taxpayers," *id.* at H12489 (daily ed. Nov. 29, 1977) (Rep. Bauman); *see also, e.g., id.* at H6088 (daily ed. June 17, 1977) (Rep. Rudd); *id.* at H6089 (Rep. Young) (both cited in *Zbaraz II*, U.S.J.S. App. 46a, n.11); 125 CONG. REC. S13574 (daily ed. Sept. 27, 1979) (Sen. Humphrey); 124 CONG. REC. H5358 (daily ed. June 13, 1978) (Rep. Lloyd); 123 CONG. REC. S11041 (daily ed. June 29, 1977) (Sen. Helms). Such isolated general

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the action the legislators explicitly took. They wished to dissociate the use of federal funds from abortion and did not take any action with regard to more sweeping anti-abortion measures.

The court of appeals also felt that its conclusion found some support in the awareness of some legislators that their actions could be construed as "legislation via an appropriations bill." *Zbaraz II*, U.S.J.S. App. 47a. The court simultaneously recognized that the Hyde Amendment, construed strictly as a limitation on the use of federal funds, would be "legislation" within the meaning of House and Senate rules against "legislation" in an appropriations bill, U.S.J.S. App. 47a, n.13, since it would impose duties and limits on the discretion of federal officials. The only legislators who specifically expressed what they meant by "legislating in an appropriations bill," did so in terms of imposing duties on federal officials. 123 CONG. REC. H6082-83 (daily ed. June 17, 1977) (Reps. Allen, Flood, Bauman, Holtzman, Hyde, Burke). No legislator ever expressed the view that the Hyde Amendment would be "legislating" in the sense of altering the substantive coverage provisions of Title XIX. Again, the court of appeals' inference is strained. The comments on which it relied are perfectly consistent with legislators' understanding of the reach of their own rules and require no inference that Congress intended to legislate far beyond the words in the bill.

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remarks, however, predicated on articulated moral objections to abortion, without any focus on the question of whether the Hyde Amendment was intended to alter the states' obligations under Title XIX, can hardly be said to demonstrate that Congress understood the Hyde Amendment to effect any such result. *See Jewell Ridge Coal Corp. v. Local 6167, UMW*, 325 U.S. 161, 169-70 (1945).

The court of appeals also stated that "[u]nlike the situation in the *Hill* case, there is no question here that Congress as a body was well aware of the implications of the Hyde Amendment and agreed to them." U.S.J.S. App. 48a. This assertion is question-begging; no one ever articulated the "implications" to which the court of appeals found such widespread agreement.

Also dependent on nonexistent statements in the debates is the court of appeals' attempt to distinguish *TVA* by noting that the Hyde Amendment was "geared specifically to the substantive provisions of the affected Act." U.S.J.S. App. 49a. Congress was certainly aware that the appropriations act before it affected federal funding for, *inter alia*, Medicaid. The silence in the debates is more striking, rather than less, where Congress is aware of a nexus between the appropriations act before it and a related substantive statute, and with virtual unanimity fails specifically to express an intent to repeal. *See United States v. Vulte*, 233 U.S. 509 (1914); *United States v. Langston*, 118 U.S. 389 (1886).

Finally, the court of appeals noted that the Hyde Amendment riders were "in the form of limiting previously authorized expenditures," U.S.J.S. App. 49a, and that the courts are "less hostile to [such] modifications via appropriations bills" than they are with respect to modifications authorizing arguably prohibited expenditures, as in *TVA*. *Id.* at 50a, n.17. Whether the cumulative decisions of the lower federal courts reflect such diminished hostility is unclear. *See New York Airways v. United States*, 369 F.2d 743 (Ct. Cl. 1966); *Gibney v. United States*, 114 Ct. Cl. 38 (1949); *NLRB v. Thompson Products, Inc.*, 141 F.2d 794 (9th Cir. 1944). In any event this Court seems not to be impressed with the distinction the court of appeals made.

See United States v. Vulte, 233 U.S. 509 (1914); *United States v. Langston*, 118 U.S. 389 (1886).

The court of appeals' conclusion is also called into question by subsequent Congressional activity. On December 11, 1979, the House passed an amendment to H.R. 4962, Child Health Assurance Act of 1979 ("CHAP"). CHAP itself would alter Title XIX in important respects and, as amended, passed the House. 125 CONG. REC. H11787 (daily ed. Dec. 11, 1979). The amendment to CHAP proposed a new section to Title XIX which would make the federal funding restriction on abortions permanent *and* relieve states of their obligations:

> None of the funds authorized to be appropriated under this title shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term; *Provided, however*, That nothing in this title shall be construed to require any State funds to be used to pay for any abortion."

Id. at H11770; *see id.* at H11776.* Rep. Bauman, sponsor of the amendment, distinguished it from the Hyde Amendments in terms leaving little doubt that he deemed those provisions to have affected only federal funding of abortions:

> I can attest as one of those supporting the Hyde Amendment language throughout its deliberations and adoption in recent years that the intention has been from the beginning to restrict Federal funding . . . . *Id.* at H11770.

* * *

* H.R. 4962 was referred to the Senate but has not yet been assigned to committee. The Senate finance committee had reported its own version of CHAP (S. 1204) in July, 1979; that version does not include any anti-abortion provision. *Id.*; *see* S. REP. NO. 274, 96th Cong., 1st Sess. (1979). S. 1204 has not yet been placed on the Senate calendar.

> [The new amendment] says that each State has the right to act for itself and impose restrictions that it may wish, whether it wants to pay for all abortions or to pay for no abortions.
>
> * * *
>
> [T]he amendment that I am offering only goes to the expenditure by the States of their own funds for abortions. It would not in any way change the Hyde amendment restrictions, for Federal funding of abortions. That is the distinction that has to be made.

Id. at 11773. Rep. Hyde agreed. He stated that the intent of the Bauman amendment was to "eliminate . . . the imposition of a Federal standard on States [to fund abortions]," *id.* at H11771, and that in the Hyde Amendment, Congress had said that "we will fund no abortions except to save the life of the mother . . . ." *Id.* at H11772; *see also id.*, at H11774 (Rep. Lungren); *id.* at H11771-73 (Reps. Waxman and Carter).*

* Reps. Bauman, Hyde, Lungren and Luken, to be sure, argued that the Bauman amendment was meant to reverse the several federal court decisions, such as the court of appeals decision here, which had held Title XIX to require the states to fund those abortions for which federal funds were available. *E.g.*, 125 CONG. REC. H11770-72 (daily ed. Dec. 11, 1979) (Reps. Bauman and Hyde). The comments were intended to explain their understanding that the Hyde Amendment had not been meant to prohibit the states from refusing to cover even the restricted class of abortions that the provision funded—that on the contrary, it had been meant to leave unaffected "the rights of the States." *Id.* at 11770 (Rep. Bauman). They expressed the view that these rights under the Act included the right not to cover any abortions under Medicaid, *e.g.*, *id.* at H11770-71 (Rep. Bauman); *id.* at H11771-72 (Rep. Hyde), presumably even ones necessary to save a woman's life. Of course, supporters of the Hyde Amendment had not articulated previously this specific understanding of Title XIX. *See* pp. 104-118 *supra*. These few remarks, from legislators who considered even the Hyde

(Footnote continued on following page)

The root fallacy of the forced arguments of the court of appeals and appellants is that they equate the anti-abortion sentiment of a majority of legislators with a directed intent to take the specific anti-abortion action of altering the coverage requirements of Title XIX—an intent which neither the measure before them nor legislators speaking on its behalf specifically expressed. This Court should hesitate to ascribe such a far-reaching action to Congress' silence respecting any intent to alter a substantive statute when the consequences of that action would damage health in an otherwise comprehensive program intended to provide medically necessary care for the poor. A step like that should be taken deliberately and by legislators, not by courts in their names.

Having lost an implied repeal argument in *TVA v. Hill*, 437 U.S. 153 (1978), and presumably recognizing that *TVA* dooms any such argument here, the United States argues instead that Medicaid, as a scheme of cooperative federalism, so thoroughly intertwines federal matching funds with requirements imposed on the states that the suspension of federal funds for a particular aspect of the program necessarily, albeit *sub silentio*, suspends the programmatic requirements. Con-

Footnote continued
Amendment too "liberal," came fourteen years after the establishment of the Medicaid program, almost seven years after the legalization of abortion in all the states, and four years after the first Hyde Amendment debates; they came after HEW had taken a contrary position and after contrary court decisions these legislators were attempting in other respects to overturn. The timing and context of these comments expose them as a belated and disingenuous attempt to read a specific abortion exclusion into Title XIX. They are not entitled to any interpretive weight. *See Regional Rail Reorganization Act Cases*, 419 U.S. 102, 132 (1975).

gress has not written any provision into Title XIX stating that each coverage requirement is predicated on federal funding. The United States asks this Court to insert such a provision into the Act by implication and thus subject public assistance recipients to the vicissitudes of the annual appropriations process. In this sense, the United States quite properly is reluctant to "disavow" (U.S. Br. 47n.27) the court of appeals' analysis; under its own approach, every appropriations measure for Medicaid (and presumably every other federal-state matching program under the Social Security Act) would repeal, by implication, pre-existing service and administrative requirements to the extent that the measure did not authorize federal matching payments for those requirements. The United States' position therefore reverses *TVA*'s strong presumptions against silent repeals by appropriations measures, and institutionalizes the contrary presumptions.

It is thus particularly surprising that the United States asserted the contrary position shortly before *TVA*. In *McRae v. Mathews*, 421 F.Supp. 533 (E.D. N.Y. 1976), on a motion in this Court for a stay pending appeal of a district court order enjoining the FY 1977 Hyde Amendment (Pub. L. No. 94-439, § 209), the Solicitor General stated:

> While Title XIX may link the states and the federal government "in a fiscal partnership to provide for medical assistance to the needy" [quoting the district court opinion], it is clear that, under the medicaid program, the states' duty to fund medical procedures covered by their plans is wholly independent of their right to subsequent federal reimbursement. Plaintiffs' constitutional rights to obtain or to perform an abortion therefore were not and could not have been restricted by enactment of the Hyde Amendment.

Memorandum for the Secretary of HEW in Opposition to the Application for a Stay Pending Appeal at 6 (U.S. Sup. Ct. No. A-346, filed November, 1977). HEW has taken the same position in response to the Hyde Amendment instruction that the appropriations rider be "rigorously enforced" by regulation. HEW's responsive regulations address only "Federal financial participation," 43 Fed. Reg. 4570 (1978), and supplemental HEW comments state:

> These regulations only govern the instances where Federal funding is available for abortions and other medical procedures. *They do not deal with the separate question of circumstances under which a State must fund abortions under the Medicaid program.*

43 Fed. Reg. 31875 (1978) (emphasis added).

42 U.S.C. § 1396a imposes requirements on the states. 42 U.S.C. § 1396b provides federal funding for most, but not all, services. Within the universe of each title of the Social Security Act, the federal-state link is between the conformity of state programs in the aggregate and the provision of federal funds in the aggregate. While the state's general participation in Medicaid is induced by federal funding in the aggregate, nothing ties each specific service requirement to federal funding.

Social Security Act programs show a federal funding pattern of variation and complexity that the United States' current position ignores. For each state the federal matching share varies from 0 to 100%, or more,*

* In one instance the state may obtain 15% of what the federal match for the service would be but for the fact that the state has provided *no medical assistance* because it has collected child support to cover the bills. 42 U.S.C. § 1396b(p)(1) (added by Pub. L. No. 95-142, § 11(a), 91 Stat. 1175

(Footnote continued on following page)

depending on the particular service or administrative function. For most items Illinois' federal match is 50%, but exceptions abound. The federal match is higher for some functions and services—*e.g.*, 90% for certain fraud detection functions (42 U.S.C. § 1396b(a)(6) (1976), *as amended by* Pub. L. No. 95-142, § 17(a), 91 Stat. 1175 (1977)), and 90% for family planning services (42 U.S.C. § 1396b(a)(5) (1976)). Other provisions provide less than normal federal match, *e.g.*, 42 U.S.C. § 603 (loss of 1% of all federal AFDC match if the state has inadequate family planning, early and periodic screening, diagnosis and treatment, or work registration programs); 42 U.S.C. § 1396b(g) (33⅓% maximum federal share for certain Medicaid nursing home and mental hospital services). And in a number of instances there is no federal match in circumstances contradicting the United States' assertion (U.S. Br. 46n.26) that Congress only denies federal funds when it imposes requirements on the states explicitly and for the purpose of maintaining pre-existing benefits. Such examples also contradict the court of appeals' additional assertion that Congress only imposes "such conditions . . . for the apparent purpose of encouraging the states to undertake programs Congress deemed to be desirable." *Zbaraz II*, U.S.J.S. App. 47a, n.12.

(a) In 1967 Congress passed legislation freezing the number of children in each state's AFDC program for

Footnote continued
(1977)). This is a bonus. Similarly, AFDC reimbursement is structured in relation to the number of children rather than to grant levels in a manner permitting some states not merely to receive a 100% federal match but to receive more and profit from some children's eligibility. *See Dandridge v. Williams*, 397 U.S. 471, 512-13 (1970) (Marshall, J. dissenting).

whom federal matching would be available after July 1, 1968. Social Security Amendments of 1967, Pub. L. No. 90-248, § 208(b), 81 Stat. 821 (1968) (adding 42 U.S.C. § 603(d)).* There was no "clear and explicit" contemporaneous legislation mandating "unilateral state funding" for such children (U.S. Br. 46n.26). Since the general provisions of the AFDC statute continued to mandate payments to all eligible persons, *see* 42 U.S.C. § 602(a)(10) (1976), the state's obligation to extend aid (rather than deny aid or create a waiting list) remained intact. Nevertheless, Congress "conditioned a state's participation in the [AFDC] program upon its willingness to assume *new* financial obligations in the absence of federal assistance." U.S. Br. 46n.26 (emphasis in original). Indeed, Congress later recognized this had been the effect when it repealed the limitation. Act of July 9, 1969, Pub. L. No. 91-41, § 3(a), (b), 83 Stat. 44 (1969); *see* S. REP. NO. 223, 91st Cong., 1st Sess., *reprinted in* [1969] U.S. CODE CONG. & AD. NEWS 1051, 1053 ("the States would still be required under Federal law to provide assistance promptly to every needy child meeting the State's eligibility standards—but the entire cost of assistance to children in excess of the limit would be borne by the States . . . .").

(b) Many aged and disabled Medicaid recipients are also eligible for Medicare, 42 U.S.C. § 1395 *et seq.* (1976 & Supp. I 1977). Coverage under "Part B" of Medicare—mainly physicians' services—requires payment of a monthly premium. States may pay premiums for the

* Imposition of this freeze was extended to July 1, 1969, and amended in part by Pub. L. No. 90-364, § 301, 82 Stat. 251 (repealed 1969).

medically needy, even though no federal matching is available for the premium payments. 42 U.S.C. § 1395v(a), (b), (h) (1976). If there is no premium payment (and thus no Medicare coverage), the state receives no federal reimbursement for those Medicaid services it provides to the medically needy which otherwise would have been covered by Medicare. 42 U.S.C. § 1396b(b)(1) (1976); 42 C.F.R. § 431.625(c) (1979).*

(c) In passing the PSRO statute, Congress provided that "no Federal funds . . . shall be used" to pay for a service properly disapproved by a PSRO on grounds of lack of medical necessity. 42 U.S.C. § 1320c-7. Under the Solicitor General's approach this cut-off of federal match alone would have sufficed to alter states' obligations. Congress did not agree, since it also explicitly imposed PSRO requirements on the programmatic aspect of state programs. 42 U.S.C. § 1320c-13. In the floor debates, moreover, Senators recognized that the PSRO provisions, if unaccompanied by repeal of comprehensiveness and maintenance of effort provisions, would leave the states under a mandate to provide services otherwise explicitly precluded from both coverage and funding by the two separate provisions of the new amendments (*i.e.*, those not medically necessary but falling under the rubric of comprehensiveness or continued because of the maintenance of effort requirement). *See* 118 CONG. REC. 33898-99 (1972) (remarks of Sens. Bennett, Long).

* For a description of the impact on the states of this Hobson's choice, *see* GAO, REP. NO. HRD-79-96, SIMPLIFYING THE MEDICARE/MEDICAID BUY-IN PROGRAM WOULD REDUCE IMPROPER STATE CLAIMS OF FEDERAL FUNDS, 42-43 (Oct. 2, 1979); *see also Doe v. Busbee*, 471 F.Supp. at 1333; *Planned Parenthood Affiliates of Ohio v. Rhodes*, 477 F.Supp. at 538, analogizing these provisions and the Hyde Amendment.

(d) Since 1975 Congress has required states to make available to non-welfare families the state agency procedures for establishing paternity and collecting child support. 42 U.S.C. § 654(6) (1976). States can charge fees for this service, but after a short period of match for start-up costs, federal reimbursement for the mandate ends: "the collection activities . . . [are] envisioned as being self-financing, unless a State decides that it does not want to charge for the costs of the service." S. REP. NO. 1356, 93d Cong., 2d Sess. 55, *reprinted in* [1974] U.S. CODE CONG. & AD. NEWS 8133, 8158 (describing 42 U.S.C. §§ 654(6), 655(a)).*

Numerous other examples can be found in the Medicaid program and in other welfare programs of substantive requirements imposed on the states without corresponding federal matching funds.** Considered in-

* The fiscal damage to the state of not paying for medically necessary abortions and incurring large additional AFDC and Medicaid costs (even with federal matching) far exceeds the cost of assuming 100% of the cost of abortions. *See Hodgson v. Board of County Comm'rs*, 3 MEDICARE & MEDICAID GUIDE (CCH) ¶30,159 at 10,074 (8th Cir. Jan. 9, 1980); pp. 7-8; 60n *supra*; *see also Preterm, Inc. v. Dukakis*, 591 F.2d at 136n.1 (Bownes, J. dissenting).

** In addition to the examples the Solicitor General cites (U.S. Br. 46n.26):

(1) There is no federal match for services (including mandatory services) to the extent that a recipient also has private insurance with a provision excluding insurance coverage for items for which Medicaid will pay. 42 U.S.C. § 1396b(o). The State Medicaid agency must therefore assume 100% of the cost of services due to the content of policies created by private insurers and permitted by state insurance regulators.

(2) 42 U.S.C. § 1396a(f) requires that certain blind and disabled persons optionally covered under Medicaid in 1972 remain covered, even when no federal matching funds for the services provided to such persons, in 1972 or at present, were or are available. *See Lewis v. Shulimson*, 400 F.Supp. 807

(Footnote continued on following page)

dividually and cumulatively these examples foreclose any attempt to distinguish the Hyde Amendment from other federal funding restrictions that leave programmatic requirements unaffected. The court of appeals discussed none of these examples; the United States' Brief cites only two carefully selected ones. Only such avoidance and selectivity permit the mischaracterizations used to distinguish them. *See* p. 124 *supra*; U.S. Br. 46n.26.

The United States asserts, without specification, that the remarks in the Hyde Amendment debates cited by the court of appeals support its position on the original relationship between Title XIX program requirements and federal funding (U.S. Br. 49). Those remarks do not

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(E.D. Mo. 1975), *aff'd*, 534 F.2d 794 (8th Cir. 1976), *cert. denied*, 430 U.S. 940 (1977).

(3) Under 42 U.S.C. § 607(b)(2)(A), a state covering AFDC families with an unemployed parent must certify that parent to the Secretary of Labor within 30 days. While the state's failure to refer would not deprive an eligible family of its right to assistance, the failure would stop federal matching funds. 42 U.S.C. § 607(c)(B).

(4) The state must license or approve as meeting state licensing standards all homes in which it places children eligible for the Aid to Families with Dependent Children-Foster Care (AFDC-FC) Program. 42 U.S.C. § 608. If it does not license or approve the homes, the state is ineligible for any federal sharing for AFDC-FC payments and services to the child, but it is still required, under Title IV-A, to provide AFDC-FC assistance "without Federal financial participation." HEW INFORMATION MEMORANDUM APA-IM-71-7 (1971).

(5) 7 U.S.C. § 2019(d) and 7 C.F.R. § 272.1(b) prohibit reduction of, *inter alia*, state-funded general assistance grants as a consequence of a family's participation in the federal food stamp program.

(6) HEW itself attempted, albeit without any statutory authorization, to withhold federal funds to the states for certain mandatory paternity determination services. *See Reser v. Califano*, 467 F.Supp. 446 (W.D. Mo. 1979).

support the assertion; but even if they did, the "post-passage remarks of legislators, however explicit, cannot serve to change the legislative intent of Congress expressed before the Act's passage." *Regional Rail Reorganization Act Cases*, 419 U.S. 102, 132 (1975). This is particularly true where, as here, the "post-passage remarks" come years after the legislation they purport to interpret and were ordinarily made by persons having nothing to do with original passage of the legislation or relevant amendments. If the United States is understood instead as arguing that the understanding of the legislators debating the Hyde Amendment can *change* what would otherwise be the interpretation of Title XIX, then it is logically identical to the court of appeals' analysis of an implied substantive change. And as such, it must overcome all the same obstacles standing in the way of the court of appeals' conclusion.

The policy of Title XIX is to provide medically necessary care to eligible recipients. Federal funding, in the aggregate, is a means to accomplish that policy or goal. *Planned Parenthood Affiliates of Ohio v. Rhodes*, 477 F.Supp. at 538. Congress, unlike the Solicitor General and the court of appeals, has never mistaken the means for the end: the purpose of Medicaid is to provide medical care, not funds to the states. Consistently with this purpose, and using aggregate federal funding as its means, Congress has cut off funds for specific items which it has "deemed . . . desirable," *Zbaraz II*, U.S.J.S. App. 47a, n.12, and items it has deemed undesirable. It has imposed unfunded requirements on the states contemporaneously and explicitly, and by implication. It has done so where fully funding the program would cost the state money and where, as in the instant case, the state would save money. It has taken the action for new and old plan requirements. It simply never has assumed

that such funding cut-offs perforce invalidate statutory requirements, or that Title XIX implicitly incorporates such a rule.

V.

THE HYDE AMENDMENT, IF CONSTRUED TO RELIEVE ILLINOIS OF ITS STATUTORY OBLIGATION TO CEASE DISCRIMINATING AGAINST WOMEN REQUIRING MEDICALLY NECESSARY ABORTIONS, AND IF ITS CONSTITUTIONALITY IS PRESENTED IN THESE APPEALS, DEPRIVES PLAINTIFFS OF THEIR RIGHTS UNDER THE FIFTH AMENDMENT.

Appellees have argued that the Hyde Amendment in no way relieves Illinois of its obligation under the Social Security Act to provide Medicaid funding for medically necessary abortions. Under this interpretation, appellees are not harmed by the Hyde Amendment, and there is no reason for this Court to reach the question of its constitutionality. Even if the Hyde Amendment is understood to relieve Illinois of its statutory obligation to fund medically necessary abortions, this Court need not reach the question of its constitutionality in these appeals. Appellees can obtain full relief against state officials. Thus, the question of the constitutionality of the Hyde Amendment has never been at issue in this case, and appellees have argued that both the district court and this Court are without jurisdiction to reach it. *See* pp. 28-30 *supra*.

If, however, this Court should construe the Hyde Amendment to relieve Illinois of a statutory obligation to fund medically necessary abortions and should reach the issue of its constitutionality, such a construction would implicate the federal government in the state action in a way that simple refusal to pay for required procedures does not. For the federal government "may

not authorize the States to violate the Equal Protection Clause." *Shapiro v. Thompson*, 394 U.S. 618, 641 (1969); *see Westcott v. Califano*, 99 S.Ct. 2655 (1979); *see also Townsend v. Swank*, 404 U.S. 282 (1971).

There is no peculiar federal interest present here to qualify this general rule of constitutional law. This Court has essentially equated the principles constraining the federal government under the fifth amendment's due process clause with those constraining the states under the due process and equal protection clauses of the fourteenth amendment. *See, e.g., Bolling v. Sharpe*, 347 U.S. 497 (1954); *Weinberger v. Wiesenfeld*, 420 U.S. 636, 638n.2 (1975).

If the Hyde Amendment is construed as an implied repeal of Title XIX's requirement that Illinois cover medically necessary abortion services, the federal government has no interest in restricting medically necessary abortions that is constitutionally distinguishable from state interests. All parties then agree that the fifth and fourteenth amendment standards to be applied here are identical (U.S. Br. 37; St. Br. 23; *see* Int. Br. 44). In those circumstances, since the restrictive Illinois abortion funding policy is unconstitutional, it follows that the Hyde Amendment is unconstitutional as well.*

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* Indeed, if Title XIX itself is construed as permitting discriminatory refusal by a state to cover medically necessary abortions, it suffers from a similar constitutional infirmity.

CONCLUSION

The appeals of the State and the intervenors should be dismissed insofar as they seek review of the earlier court of appeals decision herein. The judgment of the district court should be vacated to the extent it declares the Hyde Amendment unconstitutional. The judgment of the district court otherwise should be affirmed.

Respectfully submitted,

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March 1, 1980

APPENDIX

APPENDIX A

ILLINOIS MEDICAL ASSISTANCE PROGRAM RULES

(Handbook For Physicians)

• • •

144. Audits

All services for which charges are made to the Department are subject to audit. The initiation of audit proceedings should not be considered as an indication of any wrongdoing on the part of the provider. Rather, an audit should be looked upon as an on-going and necessary part of the procedure for monitoring health care facilities and services required by Federal regulations and State law. Providers are selected for routine audit by a random sampling of billings processed and by other criteria determined by the Department. During a review audit, the provider may be asked to furnish to the Department or its authorized representative, pertinent information regarding claims for payment. Should an audit reveal incorrect payments were made, the provider must make restitution through recoupment procedures discussed in Topic 145.

145. Recoupment

The Department will recover overpayments made to a provider resulting from improper billing practices. The determination of impropriety will be based on Department Rules and Regulations, policy and procedures stated in this handbook, and/or as evidenced by statistical data on program utilization compiled from claims paid.

The provider will be notified in writing of the nature of any discrepancies, the method of computing the reasonable dollar amount which is to be refunded, and any further actions which the Department may take in the matter.

If the provider is not in agreement with Department actions with respect to recoupment of funds paid in connection with the discrepancies noted, he may, within 10 days of receipt of the written notification, submit a request for a hearing.

The provider is to mail the written response and supporting documents to:

Review Coordinator
Illinois Department of Public Aid
Post Office Box 4466
Springfield, Illinois 62708

The Department will notify the provider in writing of the date, time, and place of the review hearing. See Section III, General Appendix 7B, Rules of Practice For Medical Vendor Administrative Proceedings, for details of the review process.

150. Fraud in the Medical Assistance Program

Providers are subject to Section 12-15.1 of Chapter 23 of the Illinois Revised Statutes pertaining to penalties for vendor fraud and kickbacks.

Title XIX of the Social Security Act, under which the Medical Assistance program is administered, provides Federal penalties for fraudulent acts and false reporting. Federal regulations for the administration of Medical Assistance programs require notification to providers of the contents of the pertinent section of the Social Security Act.

151. False Reporting and Other Fraudulent Activities

Section 1909 of the Social Security Act prohibits kickbacks, false reporting and other fraudulent activities and provides for fines and imprisonment for persons who engage in such activities. Specifically, that statute provides:

(a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this subchapter,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person, shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both.

• • •

APPENDIX B

FEDERAL STATUTES

42 U.S.C. § 1320c(1) (1976).

In order to promote the effective, efficient, and economical delivery of health care services of proper quality for which payment may be made (in whole or in part) under this chapter and in recognition of the interests of patients, the public, practitioners, and providers in improved health care services, it is the purpose of this part to assure, through the application of suitable procedures of professional standards review, that the services for which payment may be made under this chapter will conform to appropriate professional standards for the provision of health care and that payment for such services will be made—

> only when, and to the extent, medically necessary, as determined in the exercise of reasonable limits of professional discretion. . . .

42 U.S.C. § 1320c-1 (1976), *as amended by* Pub.L. No. 95-142, § 5(a), (o)(1), 91 Stat. 1175 (1977).

(a) The Secretary shall (1) not later than January 1, 1974, establish throughout the United States appropriate areas with respect to which Professional Standards Review Organizations may be designated, and (2) at the earliest practicable date after designation of an area enter into an agreement with a qualified organization whereby such an organization shall be conditionally designated as the Professional Standards Review Organization for such area. If, on the basis of its performance during such period of conditional designation, the Secretary determines that such organization is capable of fulfilling, in a satisfactory manner, the obligations and requirements for a Professional Standards Review Organization under this part, he shall

enter into an agreement with such organization designating it as the Professional Standards Review Organization for such area.

(b) For purposes of subsection (a) of this section, the term "qualified organization" means—

> **(1)** when used in connection with any area—
>
> > **(A)** an organization (i) which is a nonprofit professional association (or a component organization thereof), (ii) which is composed of licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in such area, (iii) the membership of which includes a substantial proportion of all such physicians in such area, (iv) which is organized in a manner which makes available professional competence to review health care services of the types and kinds with respect to which Professional Standards Review Organizations have review responsibilities under this part,
> >
> > . . .
> >
> > **(B)** such other public, nonprofit private, or other agency or organization, which the Secretary determines, in accordance with criteria prescribed by him in regulations, to be of professional competence and otherwise suitable. . . .

. . .

(e) Where the Secretary finds a Professional Standards Review Organization (whether designated on a conditional basis or otherwise) to be competent to perform review responsibilities, the review, certification, and similar activities otherwise required pursuant to provisions of this chapter (other than this part) shall not be applicable with respect to those providers, suppliers, and practitioners being reviewed by such Professional Standards Review Organization, except to the extent specified by the Secretary. Nothing in the preceding sentence shall be construed as rendering inapplicable any provision of this chapter wherein requirements with respect to conditions for eligibility

to or payment of benefits (as distinct from reviews and certifications made with respect to determinations of the kind made pursuant to paragraphs (1) and (2) of section 1320c-4(a) of this title) must be satisfied.

42 U.S.C. § 1320c-4(a) (1976), *as amended by* Pub.L. No. 95-142, § 5(d)(3)(B)(i), (o)(2), 91 Stat. 1175 (1977).

(1) Notwithstanding any other provision of law, but consistent with the provisions of this part, it shall be the duty and function of each Professional Standards Review Organization for any area to assume, at the earliest date practicable, responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services (except as provided in paragraph (7)) in the provision of health care services and items for which payment may be made (in whole or in part) under this chapter for the purpose of determining whether—

(A) such services and items are or were medically necessary;

(B) the quality of such services meets professionally recognized standards of health care;

. . .

(2) Each Professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

(A) any elective admission to a hospital, or other health care facility, or

(B) any other health care service which will consist of extended or costly courses of treatment,

whether such service, if provided, or if provided by a particular health care practitioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in clauses (A) and (C) of paragraph (1).

. . .

42 U.S.C. § 1320c-5 (1976).

(a) Each Professional Standards Review Organization shall apply professionally developed norms of care, diagnosis, and treatment based upon typical patterns of practice in its regions (including typical lengths-of-stay for institutional care by age and diagnosis) as principal points of evaluation and review. . . .

(b) Such norms with respect to treatment for particular illnesses or health conditions shall include (in accordance with regulations of the Secretary)—

(1) The types and extent of the health care services which, taking into account differing, but acceptable, modes of treatment and methods of organizing and delivering care are considered within the range of appropriate diagnosis and treatment of such illness or health condition, consistent with professionally recognized and accepted patterns of care;

(2) the type of health care facility which is considered, consistent with such standards, to be the type in which health care services which are medically appropriate for such illness or condition can most economically be provided.

. . .

§ 1320c-7(a) (1976), *as amended by* Pub.L. No. 95-142, § 22(a)(1), 91 Stat. 1175 (1977).

Except as provided for in section 1320c-8 of this title and subsection (d) of this section, no Federal funds appropriated under any subchapter of this chapter (other than subchapter V) for the provision of health care services or items to be used (directly or indirectly) for the payment, under such subchapter or any program established pursuant thereto, of any claim for the provision of such services or items, unless the Secretary, pursuant to regulation determines that the claimant is without fault if—

(1) the provision of such services or items is subject to review under this part by any Professional Standards Review Organization, or other agency; and

(2) such organization or other agency has, in the proper exercise of its duties and functions under or consistent with the purposes of this part, disapproved of the services or items giving rise to such claim, and has notified the practitioner or provider who provided or proposed to provide such services or items and the individual who would receive or was proposed to receive such services or items of its disapproval of the provision of such services or items.

§ 1320c-8 (1976).

(a) Any beneficiary or recipient who is entitled to benefits under this chapter (other than subchapter V) or a provider or practitioner who is dissatisfied with a determination with respect to a claim made by a Professional Standards Review Organization in carrying out its responsibilities for the review of professional activities in accordance with paragraphs (1) and (2) of section 1320 c-4(a) of this title shall, after being notified of such determination, be entitled to a reconsideration thereof by the Professional Standards Review Organization and, where the Professional Standards Review Organization reaffirms such determination in a State which has established a Statewide Professional Standards Review Council, and where the matter in controversy is $100 or more, such determination shall be reviewed by professional members of such Council and, if the Council so determined, revised.

(b) Where the determination of the Statewide Professional Standards Review Council is adverse to the beneficiary or recipient (or, in the absence of such Council in a State and where the matter in controversy is $100 or more), such beneficiary or recipient shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and, where the amount in controversy is $1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title. The Secretary

will render a decision only after appropriate professional consultation on the matter.

(c) Any review or appeals provided under this section shall be in lieu of any review, hearing, or appeal under this chapter with respect to the same issue.

§ 1320c-9 (1976), *as amended by* **Pub.L. No. 95-142, § 5(e), (*o*)(3), 91 Stat. 1175 (1977).**

(a)(1) It shall be the obligation of any health care practitioner and any other person (including a hospital or other health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this chapter, to assure that services or items ordered or provided by such practitioner or persons to beneficiaries and recipients under this chapter—

(A) will be provided only when, and to the extent, medically necessary; and

(B) will be of a quality which meets professionally recognized standards of health care; and

(C) will be supported by evidence of such medical necessity and quality in such form and fashion and at such time as may reasonably be required by the Professional Standards Review Organization in the exercise of its duties and responsibilities:

and it shall be the obligation of any health care practitioner in ordering, authorizing, directing, or arranging for the provision by any other person (including a hospital or other health care facility, organization, or agency), of health care services for any patient of such practitioner, to exercise his professional responsibility with a view to assuring (to the extent of his influence or control over such patient, such person, or the provision of such services) that such services or items will be provided—

(D) only when, and to the extent, medically necessary; and

(E) will be of a quality which meets professionally recognized standards of health care.

(2) Each health care practitioner, and each hospital or other provider of health care services, shall have an obligation, within reasonable limits of professional discretion, not to take any action, in the exercise of his profession (in the case of any health care practitioner), or in the conduct of its business (in the case of any hospital or other such provider), which would authorize any individual to be admitted as an inpatient in or to continue as an inpatient in any hospital or other health care facility unless—

(A) inpatient care is determined by such practitioner and by such hospital or other provider, consistent with professionally recognized health care standards, to be medically necessary for the proper care of such individual; and

(B)(i) the inpatient care required by such individual cannot, consistent with such standards, be provided more economically in a health care facility of a different type; or

(ii) (in the case of a patient who requires care which can, consistent with such standards, be provided more economically in a health care facility of a different type) there is, in the area in which such individual is located, no such facility or no such facility which is available to provide care to such individual at the time when care is needed by him.

(b)(1) If after reasonable notice and opportunity for discussion with the health care practitioner or hospital, or other health care facility, agency, or organization concerned, any Professional Standards Review Organization submits a report and recommendations to the Secretary pursuant to section 1320c-6 of this title (which report and recommendations shall be submitted through the Statewide Professional Standards Review Council, if such Council has been established, which shall promptly transmit such report and recommendations together with any additional

comments and recommendations thereon as it deems appropriate) and if the Secretary determines that such health care practitioner or hospital, or other health care facility, agency, or organization, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this chapter has—

(A) by failing, in a substantial number of cases, substantially to comply with any obligation imposed on him under subsection (a) of this section, or

(B) by grossly and flagrantly violating any such obligation in one or more instances,

demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, he (in addition to any other sanction provided under law) may exclude (permanently or for such period as the Secretary may prescribe) such health care practitioner or hospital, or other health care facility, agency, or organization from eligibility to provide such services on a reimbursable basis.

(2) A determination made by the Secretary under this subsection shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of institutional health care services such determination shall be effective in the manner provided in subchapter XVIII of this chapter with respect to terminations of provider agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is a reasonable assurance that it will not recur.

(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or provider to provide health care services on a reimbursable basis) such

practitioner or provider pay to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or provider of health care services which were medically improper or unnecessary, an amount not in excess of the actual or estimated cost of the medically improper or unnecessary services so provided, or (if less) $5,000. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the person from whom such amount is claimed.

(4) Any person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(c) It shall be the duty of each Professional Standards Review Organization and each Statewide Professional Standards Review Council to use such authority or influence it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners and any other person (including a hospital, or other health care facility, organization, or agency) providing health care services in the area served by such review organization, in assuring that each practitioner or provider (referred to in subsection (a) of this section) providing health care services in such area shall comply with all obligations imposed on him under subsection (a) of this section.

§ 1320c-13 (1976).

(a) In addition to the requirements imposed by law as a condition of approval of a State plan approved under any subchapter of this chapter under which health care services are paid for in whole or part, with Federal funds,

there is hereby imposed the requirement that provisions of this part shall apply to the operation of such plan or program.

(b) The requirement imposed by subsection (a) of this section with respect to such State plans approved under this chapter shall apply—

(1) in the case of any such plan where legislative action by the State legislature is not necessary to meet such requirement, on and after January 1, 1974; and

(2) in the case of any such plan where legislative action by the State legislature is necessary to meet such requirement, whichever of the following is earlier—

(A) on and after July 1, 1974, or

(B) on and after the first day of the calendar month which first commences more than ninety days after the close of the first regular session of the legislature of such State which begins after December 31, 1973.

§ 1320c-20(d) (1976), *as amended by* Pub.L. No. 95-142, § 5(d)(2)(D), 91 Stat. 1175 (1977).

(1) Each State agency may monitor the performance of review responsibilities by Professional Standards Review Organizations located within the State, in accordance with a State monitoring plan which is developed after review and comment by such organizations and is approved by the Secretary. The costs of activities of the State agency under and in accordance with such plan are reimbursable as an expense of the State agency under section 1396b(a) of this title.

. . .

(3)(A) Whenever a State agency monitoring the performance of review responsibilities by a Professional Standards Review Organization under a plan developed and approved under paragraph (1) submits to the Secretary reasonable documentation that the review determina-

tions of such organization have caused an unreasonable and detrimental impact on total State expenditures under subchapter XIX of this chapter and on the appropriateness of care received by individuals under the State's plan approved under such subchapter, and requests the Secretary to act, the Secretary shall, within thirty days from the date of receipt of the documentation, make a determination as to the reasonableness of the allegation by the State agency. If the Secretary determines that the review determinations of such organization have caused an unreasonable and detrimental impact on total State expenditures under subchapter XIX of this chapter and on the appropriateness of care received by individuals under the State's plan approved under such subchapter, unless the Secretary determines that the organization has taken appropriate corrective action, he shall immediately suspend such organization's authority in whole or in part under section 1320c-7(c) of this title to make conclusive determinations for purposes of payment under subchapter XIX of this chapter (and he may suspend such authority for purposes of payment under subchapter XVIII of this chapter until he (i) reevaluates such organization's performance of the responsibilities involved and determines that such performance does not have such unreasonable and detrimental impact, or (ii) determines that the organization has taken appropriate corrective action. Any determination made by the Secretary under this subparagraph shall be final and shall not be subject to judicial review.

. . .

42 U.S.C. § 1396 (1976).

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and

other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance.

42 U.S.C. § 1396a(a) (1976).

A State plan for medical assistance must—

. . .

(10) provide—

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter;

(B) that the medical assistance made available to any individual described in clause (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in clause A; and

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and

resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope; . . .

. . .

(13) provide—

(A)(i) for the inclusion of some institutional and some noninstitutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, and

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1396d(a) of this title, and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in clauses (1) through (5) of section 1396d(a) of this title or

(ii)(I) the care and services listed in any 7 of the clauses numbered (1) through (16) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hos-

pital services from such hospital or skilled nursing facility services from such facility, . . .

. . .

. . .

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, . . .

. . .

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients;

. . .

(22) include descriptions of . . . (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

. . .

(30) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs pro-

vided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care;

. . .

42 U.S.C. § 1396b(a) (1976), *as amended by* Pub.L. No. 95-142, §§ 10(a), 17(a), 91 Stat. 1175 (1977).

From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this subchapter, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) an amount equal to the Federal medical assistance percentage (as defined in section 1396d(b) of this title, subject to subsections (g) and (h) of this section) of the total amount expended during such quarter as medical assistance under the State plan (including expenditures for premiums under part B of subchapter XVIII of this chapter, for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, and except in the case of individuals sixty-five years of age or older and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter who are not enrolled under part B of subchapter XVIII of this chapter, other insurance premiums for medical or any other type of remedial care or the cost thereof); plus

(2) an amount equal to 75 per centum of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to compensation or training of skilled professional medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency; plus

(3) an amount equal to—

(A)(i) 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such mechanized claims processing and information retrieval systems as the Secretary determines are likely to provide more efficient, economical, and effective administration of the plan and to be compatible with the claims processing and information retrieval systems utilized in the administration of subchapter XVIII of this chapter, including the State's share of the cost of installing such a system to be used jointly in the administration of such State's plan and the plan of any other State approved under this title, and

(ii) 90 per centum of so much of the sums expended during any such quarter in the fiscal year ending June 30, 1972, or the fiscal year ending June 30, 1973, as are attributable to the design, development, or installation of cost determination systems for State-owned general hospitals (except that the total amount paid to all States under this clause for either such fiscal year shall not exceed $150,000), and

(B) 75 per centum of so much of the sums expended during such quarter as are attributable to the operation of systems (whether such systems are operated directly by the State or by another person under a contract with the State) of the type described in subparagraph (A)(i) (wheth-

er or not designed, developed, or installed with assistance under such subparagraph) which are approved by the Secretary and which include provision for prompt written notice to each individual who is furnished services covered by the plan, or to each individual in a sample group of individuals who are furnished such services, of the specific services (other than confidential services) so covered, the name of the person or persons furnishing the services, the date or dates on which the services were furnished, and the amount of the payment or payments made under the plan on account of the services; plus

(4) an amount equal to 100 per centum of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) which are attributable to compensation or training of personnel (of the State agency or any other public agency) responsible for inspecting public or private institutions (or portions thereof) providing long-term care to recipients of medical assistance to determine whether such institutions comply with health or safety standards applicable to such institutions under this chapter; plus

(5) an amount equal to 90 per centum of the sums expended during such quarter which are attributable to the offering, arranging, and furnishing (directly or on a contract basis) of family planning services and supplies;

(6) subject to subsection (b)(3) of this section, an amount equal to 90 per centum of the sums expended during each quarter beginning on or after October 1, 1977, and ending before October 1, 1980, with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable

to the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q) of this section);

. . .

42 U.S.C. § 1396b(p) (1976), *as amended by* **Pub.L. No. 95-142, § 11(a), 91 Stat. 1175 (1977).**

(1) When a political subdivision of a State makes, for the State of which it is a political subdivision, or one State makes, for another State, the enforcement and collection of rights of support or payment assigned under section 1396k of this title, pursuant to a cooperative arrangement under such section (either within or outside of such State), there shall be paid to such political subdivision or such other State from amounts which would otherwise represent the Federal share of payments for medical assistance provided to the eligible individuals on whose behalf such enforcement and collection was made, an amount equal to 15 percent of any amount collected which is attributable to such rights of support or payment.

(2) Where more than one jurisdiction is involved in such enforcement or collection, the amount of the incentive payment determined under paragraph (1) shall be allocated among the jurisdictions in a manner to be prescribed by the Secretary.

42 U.S.C. § 1396d(a) (1976), *as amended by* **Pub.L. No. 95-210, § 2(a), 91 Stat. 1485 (1977).**

For purposes of this subchapter—

The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for [eligible] individuals, . . .

. . .

whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

(2) (A) outpatient hospital services, and (B) consistent with State law permitting such services, rural health clinic services (as defined in subsection *(l)* of this section) and any other ambulatory services which are offered by a rural health clinic (as defined in subsection *(l)* of this section) and which are otherwise included in the plan;

(3) other laboratory and X-ray services;

(4) (A) skilled nursing facility services (other than services in an institution for tuberculosis or mental diseases) for individuals 21 years of age or older (B) effective July 1, 1969, such early and periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of 21 to ascertain their physical or mental defects, and such health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Secretary; and (C) family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies;

(5) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a skilled nursing facility, or elsewhere;

(6) medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law;

(7) home health care services;

(8) private duty nursing services;

(9) clinic services;

(10) dental services;

(11) physical therapy and related services;

(12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(13) other diagnostic, screening, preventive, and rehabilitative services;

(14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for tuberculosis or mental diseases;

(15) intermediate care facility services (other than such services in an institution for tuberculosis or mental diseases) for individuals who are determined, in accordance with section 1396a(a)(31)(A) of this title, to be in need of such care;

(16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h) of this section; and

(17) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary;

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases.

APPENDIX C

FEDERAL REGULATIONS

42 C.F.R. § 435.903 (1979).

The agency's policies and procedures must ensure that eligibility is determined in a manner consistent with simplicity of administration and the best interests of the applicant or recipient.

42 C.F.R. § 440.210 (1979).

A State plan must specify that, as a minimum, categorically needy recipients are provided the services as specified in §§ 440.10-440.50.

42 C.F.R. § 440.220 (1979).

If the plan includes the medically needy, it must specify that the medically needy are provided, as a minimum—

(a) The medical and remedial services in §§ 440.10-440.50; or

(b) The services contained in any seven of the sections in §§ 440.10-440.160 and, if the plan includes inpatient hospital services or skilled nursing facility services, physicians' services to recipients who are patients in a hospital or skilled nursing facility, even though physician services, as defined in § 440.50, are not otherwise included for the medically needy.

42 C.F.R. § 440.230 (1979).

(a) The plan must specify the amount and duration of each service that it provides.

(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

(c)(1) The medicaid agency may not arbitrarily deny or reduce the amount, duration, or scope of a required service under §§ 440.210 and 440.220 to an otherwise eligible recipient solely because of the diagnosis, type of illness, or condition.

(2) The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures.

42 C.F.R. § 440.260 (1979).

The plan must include a description of methods and standards used to assure that services are of high quality.